



Understanding the dynamics of health policy change

by Siobhan Harpur

FSHarpur 028338

Tasmania School of Business and Economics (TSBE)

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Acronyms and abbreviations

| | |
|-------|--|
| ABHI | Australian Better Health Initiative |
| ABS | Australian Bureau of Statistics |
| ACE | Acute Care Executive, DHHS Tasmania |
| ACHSM | Australian College of Health Service Managers |
| AEC | Agency Executive Committee, DHHS Tasmania |
| AHHA | Australian Health and Hospitals Association |
| AHPA | Australian Health Promotion Association |
| AIHW | Australian Institute of Health and Welfare |
| AIPM | Australian Institute of Project Management |
| AMA | Australian Medical Association |
| ANF | Australian Nurses Federation |
| COAG | Council of Australian Governments |
| ComET | Community Health Executive Team, DHHS Tasmania |
| CPI | Consumer Price Index |
| DHHS | Department of Health and Human Services, Tasmania |
| DI | Discursive Institutionalism |
| DoHA | Department of Health and Ageing |
| GMs | General Manager, most senior officer in Local Government |
| GPs | General Practitioners |
| HiAP | Health in All Policies |
| HPP | Healthy Public Policy |
| ICC | Integrated Care Centre |
| LGAT | Local Government Association Tasmania |
| LGH | Launceston General Hospital |
| MoU | Memorandum of Understanding |
| MPC | Multi-purpose Centre (also multi-purpose services) |
| NGO | Non-government Organisation |
| NHS | National Health Service (UK) |
| NI | New or Neo-Institutionalism |
| NPAH | National Partnership Agreement for Healthcare (Australia) |
| NPAPH | National Partnership Agreement for Preventive Health (Australia) |
| OECD | Organisation for Economic Cooperation and Development |
| PHA | Public Health Association |
| PHEX | Primary Health Services Executive, DHHS Tasmania |

| | |
|---------|--|
| RACGP | Royal Australian College of General Practice |
| SCOH | Standing Council on Health |
| TasCOSS | Tasmanian Council of Social Services |
| UTAS | University of Tasmania |

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ABSTRACT

This thesis examines the dynamics of health policy change and uses Discursive Institutionalism (DI), explained in Chapter 2, as a lens to examine the empirical case of primary health policy in Tasmania, Australia.

Health policy internationally has been slow to change from an emphasis on treating ill health to a broader focus on health improvement. There is a growing awareness that health is partly socially determined and poor health follows the gradient of relative disadvantage such that more equitable populations have better health overall.

The discursive nature of the debate regarding the causes of ill health highlights the need to analyse competing frames and values that shape contemporary health policy. A DI approach is applied in the study because its emphasis on the dynamics of change provides significant insights into policy debates central to this thesis.

The dissertation employs a case study approach that examines material relating to the Tasmania Health Plan (THP) in the period between September 2005 and May 2010. Tasmania has a population of 500,000 and relatively poor health outcomes compared with other Australian jurisdictions. The THP is intentional in taking a multi-agency and multi-strategy approach to improve the health of the Tasmanian population.

The thesis concludes that DI is a useful theoretical lens to observe the dynamics of health policy change in practice, particularly with the diversity and volume of actors and organisations, the structures of communication, and the multiple discourses. It shows that there is potential for expertise and honest brokerage to facilitate the best outcomes between governments, citizens and private and not for profit organisations. Acknowledging complexity and adapting locally. This could open the opportunity for a revival of a civil society discourse, and an investment in policymaking leadership and capability.

CHAPTER 1

1 Understanding the challenges to the practical implementation of health policy change

The dynamics of socioeconomic progress have changed. Much of human history was shaped by the struggle against infectious diseases, which gradually lost their grip as incomes rose and standards of living improved ... health must shift its focus from cure to prevention, from short-term to long-term management ... from acting alone to acting in concert with multiple sectors and partners. (Chan, 2014)¹

Today's health problems are difficult to solve because of their complexity, their multifaceted and multi-layered nature, and their rapidly changing dynamics. Economic, social, political and cultural processes operate throughout life, determining social position and cohesion, and with relative impacts on health outcomes (Wilkinson & Pickett, 2009). Problems such as obesity, alcohol misuse, narcotic drug use, increasing health inequities, demographic shifts, environmental threats, major disease outbreaks, financial pressures on health and welfare systems, and social and technological transformations all increase the need for policy innovation. The term 'wicked' problems (Australian Public Service Commission, 2007) has been applied to such issues that are difficult to solve because of their incomplete, unstable, contradictory and changing features. Many 21st century health challenges can be seen as 'wicked' problems. Attribution is complex, and linear relationships between cause and effect are hard to define. There has been a 'conflation of health with health care' (Joffe and Mindell, 2004, pg68), and policies in all sectors can have a profound effect on health outcomes and health equity. A country's health system alone has neither the capacity nor the 'steering instruments' to solve the multidimensional problems in a substantial and comprehensive way (Huynen et.al., 2005). The statement from the 8th Global Conference on Health Promotion in Helsinki, 2013 found that the "health of the people is not only a health sector responsibility, [it] requires political will to engage the whole of government in health" (WHO, 2013).

This research examines the dynamics of implementing fundamental health policy change through the interrogation of the empirical data and material relating to an

1.1 ¹ Extract from opening remarks by the World Health Organisation's Director General, Dr Margaret Chan at the UN General Assembly High-level meeting on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases. New York, 10 July 2014

intentional primary health policy approach that was developed and implemented in Tasmania. The author is a senior executive in the State health department of Tasmania and, as such, was intimately involved in the reform process as a participant observer. With a career long interest in social justice and equity, the author seeks to challenge the dominant, and arguably flawed, discourse of individual choice and market responsibility. These factors influence health policy in practice and health outcomes are largely determined by the circumstances and the potential for choices that people have in their lives. At the same time that there is a distrust in governments, there is a personal awareness that motivated the author, of epistemological positions held by public servants relating to deeply held values that are pertinent to long term ideational change. Profound questions of social justice, in terms of equity and participation are as critical as the practical considerations of service provision if a positive health policy focus is to advance. There is popular concern about the burden of chronic conditions, but the policy discussion in practice is predominantly within a biomedical, rational approach that results in policies aimed at behavioural change instead of more substantial health policy reform that acknowledges the interdependencies of social, economic and other factors.

This study was motivated by the desire to make sense of departmental interests, structures and institutions, and the realities of the ways that ideas gain traction and decisions are made. In particular the author is prompted to better understand how agents, or the ‘people power’ of authentic public engagement could gain traction, rather than the “ahistorical, atheoretical and episodic nature of contemporary public administration [that] has resulted in a disjointed approach to public knowledge where the rhetoric and reality are a long way apart” (Adams, 2004, p40). Reflecting this aim the case material in the study provides thick descriptions of institutional deliberations made possible by the author’s participant observer status, that establish an interpretive understanding of the dynamics of policy change. Shared discourse within the processes of policy development are the foundation of understanding how policy problems are addressed within governments. However this has been an under-researched area because the data is difficult to collect. The thesis seeks to look at the discourse that occurs between the sub groups from within government institutions at the State or jurisdictional level, rather than between the State and private, or the State and nationally funded services. Discourse itself can be seen as a general explanatory term or the opportunity for authentic engagement. There is an intentionally progressive development of the ‘sense-making’ approach of the author that builds through the case study chapters and the analysis, culminating in the final chapter that re-visits the case for fundamental health policy reform. The conclusion proposes that this would be possible with an acknowledgement of complexity in the structures, governance and leadership in public service.

This first chapter introduces the field of interest, starting with a consideration of health policy and then explaining why it is so contested and yet relatively static. The impact of the dominance of the rational and medically-informed health policy model

has, perhaps, limited the opportunities of developing the more complex primary and community health policy models. There is a significant difference, for example, in the way rational and political processes operate that is reflected in the way that evidence is used to inform decisions about policy and the distribution of resources.

This provides an understanding of one of the distinctive features of healthy public policy: that the divergence of primary and community health policy is more discursively *informed* from the evidence, whereas the medical model of health care policy is more historically evidence-*based*. To establish legitimacy and advance policy change, healthy public policy needs to secure support well beyond the elected politicians and the health agencies to the broader general public, the media and other sectors and agencies of government and academia. This first chapter highlights the need to understand the role and impact of institutions and actors, and the dynamics of change.

The second chapter is informed from this introductory context setting and examines a range of literature with particular reference to institutionalism and actor-based theories. There follows a substantive consideration of Discursive Institutionalism (DI) because it provides a contemporary framework for understanding complexity and systems-based approaches to policy and decision making. The features of DI are distinctive in providing an understanding of the dynamics of change via the following key research questions for the study:

1. How are policy discourses constructed in the 'coordinative sphere'²?
2. How does the diversity and volume of actors and institutions contribute to complexity?
3. How observable is the dynamic of change?

The subsequent methodology chapter describes the constructivist and interpretive approaches to the research philosophy. DI is then described as the theoretical lens that is applied to the analysis of the empirical documentation of the Tasmania Health Plan (THP) that is included in the case study chapters that follow.

There are three chapters of interrelated case studies that are structured to broadly follow the same general structure, covering the institutional arrangements, the engagement strategies and the impact or intended outcome.

² Coordinative and communicative are the internal and public spheres of communication identified in the DI literature

The key research questions informed the selection and interpretation of the case material and were applied to the same structure to feature different aspects of the key research questions in the following way:

| Key research questions | Case study chapter | Theory applied to the choice and interpretation of the case material |
|---|--|---|
| 1. How are policy discourses constructed in the coordinative sphere? | Establishing the case for a primary health services plan | Questions 1 and 2: Moving the discourse from the communicative to the coordinative sphere |
| 2. How does the diversity and volume of actors and institutions contribute to complexity? | A tiered service delivery model | Question 2 and 3: The agents of change – who they are and how they convey the ideas |
| 3. How observable is the dynamic of change? | Developing a chronic disease strategy | Questions 1 and 3: How and where the ideas emerge and the observation of the interactive processes of a developing discourse |

Figure 1 Structure of the analysis

The analysis chapter that follows interrogates the case study chapters through the lens of DI and using the research questions, drawing from the context established in the introductory chapter and the literature review in Chapter 2.

Chapter 7 closes with a critique of the limitations of DI theory to the research question of understanding the dynamics of health policy change. This then leads to the concluding chapter that explores complex adaptive organisations and policymaking, and the potential of leadership and policy transfer to make fundamental health policy change.

There is a slow but evidential change in health policy, from the rational, scientific and technical curative model toward recognition of the dynamic and complex social and economic impacts on health. However, the implementation of a broader ‘health in all’ policies approach is still relatively immature and challenging. In introducing these policy and sub-policy areas of health, this first chapter reveals the significance of the interactions between agency and interests, the dynamics and complexities of change, and the contribution that organisations play in the legitimisation of ideas and policy reform.

The remainder of this chapter is organised in two main sections. The first of these covers health policy within the context of public policy. It identifies that health itself is defined by values and positions, that health care is structured differently and that funding mechanisms vary in different countries and within Australia. Finally, the first section closes with a consideration of health policy in relation to chronic conditions, which are both the most significant burden of ill health and the greatest policy implementation challenge for governments everywhere. The second section of this chapter covers primary health and health promotion, and considers how this subset of health policy could play a part in reducing the burden of chronic conditions. It explores the growing disparities of avoidable inequity and explanation of the contemporary discourse for systemic health improvement that started as 'healthy public policy' and has more recently been refined to 'health in all' policies. This raises the question of what determines the health of the population, what we do individually and collectively about this, and what is determined through politics and public policy. Policies and program choices have an impact on education, employment and environmental protection. Each of these factors together with many others has an impact on the health outcomes of individuals and whole populations.

The chapter closes with a reflection on the relevant features of health policy that have been identified as relevant to the research and how each of these inform the theoretical review of the literature in the next chapter.

1.1 Health is a complex and contested policy area

1.1.1 What constitutes health policy?

Health policy is described as being concerned with the distributional decisions that allocate "tangible benefits and services across various interests in society" (Palmer & Short, 2010) p48. It therefore contributes to shaping popular beliefs about health problems and how they should be managed. Health care is on the public agenda and generally it is the subject of crisis commentary in the media, especially highlighting the various inabilities of governments and health leaders to manage costs, meet demands, or to provide clinically safe care (for example in Australia: (Armstrong et al, 2007; Gregory, 2010), and elsewhere, (Beland, 2010; Marmor et al, 2005; Hacker, 2004; Brown, 2012).

In the developed OECD countries health costs have been rising faster than GDP. The Australia Health Report in 2014 (Australian Institute of Health and Welfare, 2014), for example, shows health costs have increased by 5.4 per cent per year compared to an annual GDP growth of around 3.1 per cent in Australia. This could be potentially sustainable; however, the majority of expenditure is on hospital care,

medical procedures and pharmaceuticals. Grattan Institute Reports in 2013 and 2014 (Duckett and Breadon, 2013; Duckett, 2013a; Duckett and Breadon, 2014) have identified savings in the Australian health policy expenditure that include reducing inefficiencies in public hospitals and benchmark pricing for generic pharmaceuticals and better use of patented pharmaceuticals. At the same time there is a continuing escalation in the levels of obesity and other lifestyle-related disease (with obvious health consequences) in high and middle income countries, and which is not attracting any significant changes in policy or resources to combat it (Gortmaker et al, 2011).

The significance of health policy decisions impact everyone in society and policymaking is not a single decision; rather it is a web of decisions that take place over time, and that embrace the conflicts and tensions within and between politics, culture and technical information (Lin & Gibson, 2003 pXX1). Community expectations for the public provision of services, however ill-defined, have continued to rise, and health policy continues to be a significant concern of governments everywhere.

The reasons for the slow changes in policy are, arguably, because of the increasing complexity and contestability of health policy within governments. This is particularly with reference to the multiple modes of delivery and the involvement of all levels of government including, the market and the costs, as well as the benefits and profits for many of the participants. These challenges are also, arguably, rooted in the range and diversity of vested interests that impact on the functions of the political process, which in turn are a determinant of policy (drawing on the policy types identified by Lowi (1972). Even bitterly unpopular policy can become the norm when new programs create their own constituencies, especially if there are financial benefits that flow to some participants and new structures are established around them. The British Medical Association was, for example, fiercely opposed to the introduction of the UK National Health Service (NHS) in 1948 and later became its strongest defender (Boxall and Gillespie, 2013). More recently in Australia, Nicola Roxon, the Health Minister in the 2007-2010 Government received opposition from the Australian Medical Association when she attempted to reduce the payment for cataract surgery under the Medicare Benefits Schedule, without success. The Telegraph, for example, stated (Akerman, 2009):

Roxon has claimed the procedure takes 15 to 20 minutes, but an AMA survey suggests 70 per cent of ophthalmologists take between 25 and 40 minutes to perform it... Roxon's goal is to destroy the medical profession through a campaign of denigration and assault on the integrity of doctors. Her desire is to replace medical professionals with cheaper, less qualified nurses.... [S]he is a failure in this portfolio. She must be moved: the health of the nation is too precious to be left in her inept hands.

The evidence is that organisational structures, particularly those of Government, are relatively stable and likely to continue to be slow to change, especially when mainstream discourse is dominated by the media.

The political science analysis of health policy has tended toward rational and deductive approaches to explain the general stability in health policy activity since the 1980s in English speaking countries such as Australia and Canada, together with much of Europe. Hacker (Hacker, 2004), for example, states that there is more evidence of “reform without change and change without reform” with a net result of only marginal changes in publically-funded health care, and a relative stasis in the health policy approaches taken by Australian governments of all political persuasion since the 1990s (Boxhall & Gillespie, 2013). What is becoming increasingly apparent is that there is a focus on the structures of jurisdictional health authorities and that over time the changes have swung from more to less centralisation and back again, with no clear direction overall.

Restructuring is so pervasive, in fact, that observers could be forgiven for thinking it is the only change tool available. In the health sectors of Britain, New Zealand, Canada, the USA and Australia the activity seems virtually continuous. Primarily it consists of regular mergers, altering the responsibilities between central and peripheral bodies, setting up new agencies that trigger domino-like changes to the official responsibilities of other agencies, constantly tweaking organizational charts and re-orienting who reports to whom... The evidence for this making a difference, let alone demonstrably improving productivity or outcomes, is surprisingly slender. (Braithwaite et al, 2005, p542)

Most Australian health jurisdictions have undergone review and subsequent reform of their health systems over the last decade. The organisational structure of federal government in Australia, as in the USA and Canada, has influenced health policy like many other areas of public policy. There have been decades of tension between the respective institutions and levels of government evident in the long term ‘blame game’ that ebbs and flows from one to the other depending on the particular articulation of failure. Boxall and Gillespie (2013) discuss both the opportunities of experimentation and innovation in the early years of government-funded health service development, as well as the fragmentation that has been more common since the subsidised medical insurance started in 1954.

“[...] if health providers avoided competition or states remained immersed in cost-shifting games rather than improving health services, the answer was

seen in stronger central government intervention... the Hon. Tony Abbott as Health Minister in 2005 declared: “the only big reform worth considering is giving one level of government – inevitably the federal government – responsibility for the entire health system” (Boxall & Gillespie, 2013, p160).

One feature of Australian health policy that has been attributed, at least in part, to the fiscal arrangements of federalism is that it has resulted in a strong emphasis on the pressing high cost of hospitals (a responsibility of the State governments) and may have contributed to the lack of a coherent and consistent primary health policy in Australia. The health policy debate is regularly focused on federalism, and a stronger national policy capability in Australia is required in order for this to function. Fenna (2013), for example, makes a case for the benefits of multi-level government, despite the observation that the health policy debate is regularly focused on shifting the blame between national and sub-national levels of government in Australia, USA and Canada. In terms of health policy in particular, Greer and Jacobson (2010) outline a model of state service delivery with a federal financing and policy framework setting for the USA, that could result in better health outcomes overall.

This section has described some aspects of the contestability of health policy and highlights the need to better understand the factors that cause change and asks if they can be identified, can they be observed? This leads on to a consideration of what ‘health’ entails.

1.1.2 Health and health care definitions

Health has its origins in the old English “hale” or “hoelth” meaning whole or sound,³ and has come to be identified in a number of different ways. On the one hand, there is the dominant biomedical discourse that deduces individual diseases and conditions in order to determine relevant treatments, and the more recent adoption of the term wellbeing to infer a balance of physical, mental and spiritual wellbeing. Health has been described as a human right, an ideal and a resource for life by the World Health Organisation (WHO 1948; 1986; 1978). The Australian Bureau of Statistics defines health as;

“a concept that relates to and describes a person’s state of being. It is therefore highly subjective. Good health means different things to different people and its meaning varies according to individual and community expectations and context” (ABS, 2001).

³ Dictionary definition, Merriam-webster

The socio-ecological approach described by Keleher (2004, p4) sees health as a multifaceted set of relationships that determine health, with particular attention paid to equity. Health equity is different from inequalities which are inevitable because of some absolute differences in that it can be determinable based on access, understanding, resources and power. Health is now understood to be the product of complex and dynamic relations that are generated by numerous determinants at different levels of governance (Kickbush & Behrendt, 2013). Baum considers each of these different understandings from the Australian health policy perspective (Baum 2002) and finds that the biomedical approach is the one most conventionally applied and, at the same time, is lacking a comprehensive explanation of health. The wider role of health in society tends to surface at critical points of societal change, such as the rise of the industrial society in the 19th century and the development of the European welfare state after the Second World War. Health has not only shaped the modern state and its social institutions in Europe over the past 150 years, but has also powered social movements, defined the rights of citizens and contributed to the construction of the concept of the modern self and its aspirations (Kickbusch, 2007).

During the last thirty years there have been major changes in the ways that governments organise and deliver health services. These are reflected in service structures as well as in the changes in community expectations since the Second World War. These have generally run ahead of the capacity of government to respond to them and are matched with a strong resistance from the general public to paying more in personal taxes (Davis & Weller, 2001). There has been an increased application of markets and market-type policy instruments, linked with a retreat from direct service delivery. Some (Halligan, 1995; Peirre & Peters, 2000) assert that there has been a failure of neo-liberalism and the public choice theory (as evident in contracting out, the splitting of service purchasers and providers, and quasi-marketing of health services) to meet the need for more political and qualitative instruments for policymaking. Whatever the reality, these changes in government have further impacted on creating a more holistic policy reform responsive to the prevention and management of chronic conditions, and maintained the health policy focus on treatment.

Evidence-based medicine may provide one of the explanations for maintaining a narrower definitional focus of health care. Evidence-based medicine has, Baum argues, much in parallel with Fordism⁴ with increasing degrees of deductive decision-making and the centralization of control. This is a sharp break from the management of health service delivery in the 1980s in Europe and Australia, which left most clinical choices to clinicians. Arguably this could be why population health outcomes are still seen to be principally an aggregate of the choices made by clinicians, together with the negotiated support of their organisations. This concurs

⁴ Business dictionary.com defines Fordism as the manufacturing philosophy that aims to achieve higher productivity by standardisation of processes to reduce costs.

with the work of Archie Cochrane, another UK Public Health specialist who published “Effectiveness and Efficiency: Random Reflections on Health Services” in 1972 (Palmer & Short, 2010). The principles Cochrane set out suggested that because health care resources would always be limited, they should be used to provide interventions that had been reliably tested by the evidence. Cochrane’s propositions were widely recognised as seminally important and gave rise to the random control trial as the preferred method for determining the effectiveness of a given intervention.

However, health outcomes, arguably, could only genuinely be improved through the attribution of factors beyond the specifics of health care. Black, for example (2001 p277) argues:

[The] need to recognise that the other legitimate influences on policy (social, electoral, ethical, cultural and economic) must be accommodated and that evidence-based research is most likely to influence policymakers through an extended process of communication.

In addition to the macro changes in governments, the strength of particular interests and the views and methods of health policy analysis, evidence-based medicine is strongly influencing health care decision-making and policy.

Another influencing factor on health care decision-making is clinical governance. Governance itself is commonly used as distinct from government in that it is a mode of coordination in decision-making based on networks rather than on hierarchy (Davis & Weller, 2001). In contrast to this, the clinical governance agenda is arguably the most systematic strategy for controlling clinical behaviour that has ever been attempted since public health services were established. Clinical governance frameworks are ‘scientific’ in the sense of relying substantially on an external body of knowledge, and also ‘bureaucratic’ in the sense of relying on rule-based implementation. A scientific-bureaucratic model is based on the assumption that there is a ‘best practice’ model of care or clinical practice trajectory. It has steadily become the conventional wisdom that the validity of particular clinical interventions should be measured by the hierarchical or systematic assessment of research. The critical argument is that the whole discourse is premised on there being an explicit means-end claim for a particular mode of care, rather than a valuation of the process of care itself (Lin & Gibson, 2003).

This is strongly contrasted with the more reflective practice model for clinical care, most commonly found in nursing, which tends to create a culture of inquiry and learning. Arguably this is most appropriately suitable for contemporary health care

practices and more conducive in particular to the treatment and care of people living with chronic conditions.

This discussion has demonstrated the diverse ways in which health is understood, and that perspectives are driven by ontological interests as well as epistemology. This highlights the need to better understand how ideas are constructed, and sets the scene for this particularly within institutions.

1.1.3 Structures and funding for health care

The major types of structure for health systems are: universal care provided to citizens through a national health service, a national health insurance scheme, or a combination of the two. Canada has a health insurance scheme which is actually more closely aligned with the UK NHS than the health insurance programs in, say, Germany or France. This is because the medical facilities, including hospitals and primary care, are mostly publicly-owned in both Canada and the UK. In contrast, the German model that is common to other European countries is a more 'corporatist' style, with a payment for health care based on insurance within a public regulatory framework. The costs of clinical care systems within any of these structures continue to increase with technology, treatment modality and pharmaceutical developments as well as ageing populations. The sustainable financing for healthcare and health policy is of significant concern for governments everywhere. The major types and structures of health policy financing are summarised as follows:

Ownership of Medical Facilities

| | Single payer | Multi-payer |
|----------------------|--|---|
| Mainly public | National Health Service (UK) <ul style="list-style-type: none"> • Tax financing • Salaries or capitation • Large share of care is publicly financed | National Health with Insurance (Australia) <ul style="list-style-type: none"> • Tax financing • Salaries and private • Out-of-pocket costs • Diverse coverage |
| Mixed public-private | National Health Insurance (Canada) <ul style="list-style-type: none"> • Tax financing • Fee for service | Corporatist Health Insurance (Germany) <ul style="list-style-type: none"> • Payroll financing • Fee for service • Diverse coverage |

Figure 2 Major types of medical systems based on (Hacker, 2004 p696)

The general characteristics of health policy in Australia are broadly similar to and derived from other countries and have much in common with parts of Europe, particularly the UK, and parts of Asia. Health care policy in the USA and Canada in practice share some of the characteristics of southern Europe, with a mix of national

and regional level government responsibilities together with private sector service provision. In Europe there are broadly three health policy types based on historical groupings (Evans, 2005). While Marmor (2005) cautions the limitations of comparing health policies for the purpose of cross-national learning, observing that there are many factors that influence the arrangements, while there is a congruent perspective in terms of a broad review of health policy and change.

In Scandinavia, universal public provision of health is the norm and it has incrementally evolved without significant points of change. In central Europe in the past there were specific points in the introduction of universality in health care: 1883 in Germany, 1941 in the Netherlands, 1948 in the UK and the late 1940s in France. The transformation of the post-war political landscape opened the window for change in France and the UK, but the forces had already been set in motion before then, stemming from the early 20th century popularity of socialism, and the establishment of a national insurance scheme in the UK in 1911. The southern Mediterranean countries by contrast have a mix of insurance schemes, private practitioners and public services. The middle and southern European systems have greater similarities with the Canadian, USA and Australian health system policies than those in Northern Europe.

The diversity in the range of institutional structures, private and public mix of service provision and financing is illustrative of the complexity of the policy field. Primary and community health care in Australia is, arguably, the most complicated in terms of financing structures, split between State financed services and private general practice. General practice financing is achieved through a combination of national commonwealth payments against specific treatments and out of pocket payments by patients. Jurisdictionally, each State provides a variable level of primary and community health services, and contracts services through the community non-government sector and local Government. This may provide some explanation of the general lack of understanding of health policy for citizens as well as the actors within institutions. This leads to a consideration of the change in emphasis from treating infectious diseases to managing and preventing chronic conditions, and the impacts this has had on health policy approaches.

1.1.4 Chronic conditions are the most significant burden of ill health

The prevention and management of chronic conditions provide a focus for examining the diffused impacts of health policy change over time because they have taken decades to become the dominant cause of ill health. Chronic conditions need management over time, with intermittent treatment interventions, and the management of symptoms to slow the advance of potential complications. The management and treatment for people living with chronic conditions requires new

ways of working that takes account of the individual and their experience. This change from the treatment of infectious disease to the prevention and management of chronic conditions is recognised as needing to impact the structures, governance and interactions within the health and community services system.

This would acknowledge the permeability of professional, personal and organisational boundaries, as well as challenge the prevailing discourses of health care institutions and professional practice.

Chronic and non-communicable conditions now account for more than 80 per cent of premature deaths in developed countries and are expected to account for seven out of every ten deaths in the whole world by 2020 (WHO, 2011). There is a widespread public concern about reducing chronic disease, but currently of the approximately 98 per cent of government health spending allocated to health care treatment by most Organisation for Economic Cooperation and Development (OECD) countries, only two per cent goes to the prevention of ill health (OECD, 2013). Two-thirds of that two per cent is spent on screening and immunisation programs. The January 2011 statistics from the USA reveal that diagnosed cases of diabetes, for example, cost the country \$174 billion US dollars per year, of which \$116 billion is spent on direct medical treatment and care (Krech, 2011).

Primary health care is the first level of contact that individuals, families and communities have with the health care system. The links between services and providers at the local level is generally important to improve coordination and continuity of care. This is of particular importance for the care of children, older people and any sub-populations or communities likely to be at greater risk of complexity in terms of medical or social needs. Primary health has a wider definition than care; however, the normative health care structures and institutions that were established around the episodic treatment of ill health tend to dominate. This broader requirement for health is only peripherally considered within health policy analysis. Yet while economic, technological and scientific progress has impacted on increasing life expectancy, the greatest health advances in most of the world have arguably been more substantively because of social and environmental improvement (Baum, 2002; Lin & Gibson, 2003). These sources of improvement are considered in the next section of this chapter. It is, perhaps, the infrastructure investment in hospitals that occurred since the 1950s that has contributed to the structural resistance to change. This structural resistance is upheld by the professional interests of the medical professions in particular, as well as associated industries including pharmaceutical, pathology and radiology, and surgical equipment suppliers, which are all bound into interdependent relationships through the service supply and demand.

The term 'connected care' was used in the UK by the Institute of Public Policy Research in its 2004 report on meeting the needs of people with chronic conditions

(Rankin & Regan, 2004). This analysis found that service access and service response was found to be particularly poor for people whose needs were complex in either breadth or depth. Services would rarely recognise the interconnected challenges of physical, social and emotional needs and their relationship, for example, to poverty. Some of the strategies to improve service response included:

- a single point of entry and referral
- service navigators to provide advocacy, support and coordination
- shared information between provider organisations
- assertive outreach and managed transition between services.

As early as 1968, the Seeborn Report (1968) advocated that social services departments in the UK needed to be a 'single door on which everyone could knock'. Greater collaboration and the need for better coordination of care between agencies has been a long-term aim for local governments and health services in Australia as well,⁵ but continues to be challenging in the practical application of policy. There are conflicts over the issue definitions as well as the intended outcomes, and the concepts are not adequately translated from the macro- 'big picture' through the 'meso-' level of professionals and organisations, to the 'micro-' level of understanding by individual professionals, politicians and citizens (Shannon, 2004-5). Decision-making about resource distribution at the institutional level tends to ignore the health consequences of public policy decisions, seeing these as political failures. Health professionals working at the micro-level will continue to fail to collaborate across agencies while there are no institutional gains or evidence of the benefits of effective decision-making in the health system at meso- and macro-levels.

This section has articulated some of the complexities of health policy change in practice by focusing on the burden of chronic conditions. A major question which needs addressing is how the processes of change occurs, and whether there are particular subsets of the policy process that are particularly important and open to empirical analysis and critical study. This research is especially interested in whether the discourse and the development of ideas is among particular actors or within and between particular institutions, and how the structural or other disincentives for change inhibit action?

1.2 Primary health and health promotion are a subset of health policy

⁵ Coordinated Care Trials, Australia 2004–2006

1.2.1 The emergence of health promotion

There is broad acceptance that the priorities for health care need to change in order to manage the burden of chronic diseases (WHO Regional Office for Europe, 2011; WHO, 2011b; WHO, 2005). In the 1970s there were a number of concurrent advances in health policy that began with the Canadian Government's 1974 Lalonde Report⁶ that recognised environment and lifestyle impacts on health. This report was influential in broadening the international debate. The report was stimulated in part by the seminal work of the British epidemiologist Dr. Thomas McKeown (1976) titled "The role of medicine – dream, mirage or nemesis?". McKeown observed: "I have no difficulty in dating the origin of my own doubts about the conventional assessment of the work of doctors," (McKeown, 1976, pix), and went on to argue that health care made only a minor contribution to the massive improvements in population health outcomes between the mid-19th and mid-20th centuries. He wrote that "there is a need for a shift in the balance of effort, in recognition that improvement in health is likely to come in the future, as in the past, from modification of the conditions which lead to disease, rather than from intervention in the mechanism of disease after it has occurred." (McKeown 1976, p195).

The global conference at Alma-Ata (WHO, 1978) referred to primary health care as essential health services that are provided as close as possible to where people live. This same declaration referred to the need for a health policy approach that extends outside health care to the social and economic development of the community. These extended features of primary health policy approaches were variously applied in Australia and described, for example, as "principles for a health care policy" in the 1992 report that reviewed the role of primary care in health promotion (Palmer & Short, 2010 p228). The features identified as important included: collaborative networking, community participation, balancing health care priorities between the immediate and long term needs, and partnering with secondary and tertiary sectors. These provide a bridge between health care and communities, and extend the objective to reorient the health system toward the promotion of health from the biomedical model to a social one (Bunker, 2001).

This primary health thinking became more sophisticated internationally during the late 1970s and 1980s and the Ottawa Charter for Health Promotion (WHO, 1986) was seminal in describing the complementary approaches including legislation, fiscal measures, taxation, and organisational change that would improve health. It was the

⁶ Known as the Lalonde Report, Marc Lalonde was the then Canadian Minister of Health and Welfare, and the 76 page Government Report demonstrated that health policy priorities were drawn primarily to the financing and delivery of medical care, with too little attention given to the many other influences on health.

recognition that it was the coordinated action of social policy which fostered greater equity and capacity, together with fiscal policy which would ensure access to healthier goods and services that would have an underlying or “up-stream” impact on better health outcomes for individuals. Figure 2 illustrates these dimensions of approaches that are described sometimes as a framework for health promotion action, and are needed in combination to make a difference to health outcomes over time. They are particularly needed to articulate an understanding of the need for a combination of policy approaches that are required to make a difference overall, and their relative importance and difference to each other (Keleher & Murphy, 2004, p160).

The table that follows outlines an explanation of the types of approaches or interventions that can be applied at each of the levels of interaction with the health system. The table also indicates that the interventions apply to the policy approaches with individuals, organisations, sectors and at the sub-national and national policy levels. It has been adapted from Keleher & Murphy (2004) and a further ‘upstream’ column added to consider the implications for structural redistributive policy. This could include models of capitation (block funding instead of fee for service) at the primary level, through formal partnership arrangements, to payment on outcomes measures at the tertiary levels of health care.

| Interventions | | | | | |
|---------------------------|----------------------------------|---|---|---|--------------------------------------|
| Downstream | | | | | Upstream |
| Disease prevention | Communication strategies | Health education and empowerment | Community and health development | Infrastructure and service improvement | Systems Change and investment |
| <i>Primary</i> | Health Information | Knowledge | Engagement | Policy | Capitation |
| <i>Secondary</i> | Behaviour change campaigns | Understanding | Community action | Legislation | Public private partnerships |
| <i>Tertiary</i> | | Skill development | Advocacy | Organisational change | Outcomes payment |
| | Lifestyle and behaviour approach | | Social policy approach | | Structural re-distributive policy |

Figure 3 Adapted from Keleher and Murphy (2004, p160)

Health and wellbeing were promoted within health policy during the 1980s, and the discipline of health promotion established as a result of these insights. Health policies were deliberately articulated to promote health, and it was the first time that social and welfare policy was acknowledged to have a specific impact on health outcomes. The Alma-Ata conference called for urgent reform to create a health system focused on wellbeing and health promotion, rather than the treatment of diseases. But despite the high level support and normative recognition of the proposition, and despite numerous reiterations of this commitment since 1978, many

(Clavier & de Leeuw 2013a; Bambra et al 2005; Baum 2002; Baum & Fisher 2011; Labonte 2011; de Leeuw, 2011) would argue that there has been little substantive progress by governments to advance health policy change, particularly in the middle and higher income countries.

The growing epidemiological concerns that include increased lifespan, urbanisation and lifestyle behaviour change, the prevalence of chronic disease, and a need to establish new delivery systems to provide comprehensive access, are health policy challenges faced by all countries. Arguably the strongest feature of the movement toward promoting health has been very selective, focusing on lifestyle and behavioural changes in order to prevent or slow the trajectory of diabetes and other high prevalence chronic conditions. This emphasis on the individual, however, can miss the broader social and environmental impacts on population health. Despite significant progress, there remains a widespread inequitable access to health care in general, while community-based and primary health care services are often inadequately organised, understaffed and poorly funded.⁷

This section has described the origins of primary health policy and the development of the ideas and discourses internationally, and referenced the intersection with multiple sources of information, markets and sectors in influencing health policy change over time. It has emphasised the poor incorporation of health promotion in effective policymaking, despite the widespread recognition of the need, value and economic benefits of such a reorientation.

1.2.2 Health inequities and health outcomes

Economic analysis throws light on the ‘private world’ of personal lifestyle choice, as well as the societal and public policy choices available to governments and industry. So while a person can consciously choose options every day to maximise health and well-being – like vaccinating their children, eating nutritious food and cycling to work – governments influence the ‘choice architecture’ by making healthier options more or less available (free health care, price incentives, bike paths) (Sheill et al, 2013, p1).

It is useful, arguably, to better understand this broader health policy field by considering social policy which has been highly contested over the same period, particularly in regard to ‘entitlement’ (Beland, 2010). Analysis in social policy is, similarly to health policy, currently often focused on the economic orthodoxy that

⁷ Human Development Report 2003 – Millennium Development Goals: A Compact among Nations to End Human Poverty, Human Development Indicators, 2003.

cause a requirement for fiscal austerity in governments at every level. And yet support, and indeed provision, for health and social care remain widespread and relatively stable in affluent countries. The politics centre on the “renegotiation, restructuring and modernisation of the terms of the post-war social contract rather than its dismantling.”(Pierson, 2001).

The language of public policy is becoming more complicated and it includes more convoluted extrapolations of meaning and construct than ever before. However, the strategies of engagement in a public discourse is often rhetorical and deliberately symbolic and simplistic, with the real control of the agendas, the debates and the decision-making firmly retained by the elected leadership (Adams & Hess, 2001). ‘Social Capital’, like many of the other terms used in the current discourse, such as ‘place management’, ‘holistic’ or ‘joined-up’ government, and community governance, are set in a context of collective responsibility which is actually highly moralistic, conservative and constrained. This civil governance discourse is further explored by Bell (Bell, S & Hindmoor, A 2009) who identify that despite the marginalisation of formal deliberation and consultation policy processes, governments are still central in making policy happen. Power is maintained within governments, albeit differently constructed, and those without power are increasingly disempowered and, more than ever, the passive recipients of services.

The socioeconomic view of health gives consideration to avoidable health inequities. There is longitudinal evidence that people living in poorer social and economic circumstances experience worse health, and that they are at risk of multilevel disadvantage with the additional burden of ill health. These avoidable health inequities are increasing with, for example, Australians with the lowest income having more than two and a half times the risk of getting diabetes relative to people who are in the top income quintile (Duckett, 2013b). Health inequities are evident in the fundamental health outcome of life expectancy, and there is a marked correlation between socioeconomic disadvantage and higher levels of psychological distress⁸.

Health inequalities begin with living conditions, difference in income, employment and levels of education. The National Centre for Social and Economic Modelling (NATSEM) calculated the rates of poverty by jurisdiction by considering the disposable income of households and concluded that the high levels of poverty in Tasmania (for example) are a result of very low median incomes, and a high reliance on government income support payments (NATSEM, 2011). The intersection with social policy is strongly articulated through the works of Armatya Sen (1999), and the relationship with health policy by Sir Michael Marmot (2004). Health policy has relative impacts such that low income may cause ill health or that poor health may

⁸ See, for example, Statistics, ABS. 2013. Information Paper: Measures of Australia's Progress Proposed Statistical Indicators, 2013 *In*: ABS (ed.). Canberra.

cause lower income. Income and health may each correlate with other factors or all may be causative simultaneously. Marmot's work on the study of Whitehall civil servants (Marmot, 2004) demonstrated that the gradient, or relative and proportional relationships, have causative impacts on health inequities and inequalities. The Acheson Report (Department of Health, 1998) is a leading example of redistributive policy prescription for addressing health inequities through health policy reform.

This section has introduced a further rationale for understanding health policy change toward a more health promoting approach, with a particular focus on the cost of inequality and that more can be done to reduce avoidable inequities for the benefit of all populations.

1.2.3 Primary health and health promotion policy and practice

The three issues of greatest concern in terms of primary health care reform internationally and in Australia were identified in a literature review by UNSW in 2004 (McDonald, 2004) as:

- Providing alternatives to hospitalisation
- Providing care for people with chronic and complex conditions in collaboration with more specialised health services
- Population health and prevention

The benefits of primary health care are widely documented, including the work of Starfield (1994) that demonstrated the independent effect of improving health status and reducing health inequalities in countries through well-developed primary care sectors⁹. The literature on primary health and primary health care is strongly focused on collaboration. However, there remains confusion in Australia because of the fragmentation of health care, and particularly between primary and secondary care funding arrangements between the Australian Government and the States and Territories. The Australian Government is responsible for Medicare and the Pharmaceuticals Benefits Scheme, and the jurisdictions are responsible for hospitals and specialist care, and this extends to primary and community services that are also directly funded on a fee for service basis. This contested space became more clear with the April 2011 COAG Agreement for National Health (Council of Australian Governments [COAG], 2011). This identified the Australian Government as the

⁹ Starfield accounts for the beneficial effects of primary care and makes the distinction from the more 'medicalised' definition in common use to better align it with the Alma Ata definition.

provider for aged care, and the States and Territories for community health, as follows (COAG, 2012) :

“(P7): ‘States and Territories will fund:

(a) community health;’

And (P8)

‘.. the Commonwealth will fund:

... (b) assist in reducing pressure on hospital emergency departments through the provision of funding for primary health care services;”

On the one hand, there remains a policy overlap and lack of definition of the difference between ‘community’ and ‘primary’ health services, and on the other hand, a gap between the fee for service primary health care provider model and acute care. This is particularly evident for people living with multiple co-morbidities whose care will span public and private, as well as national and locally funded services that are not seamless or ‘joined together’ for the patient. The Australian Government published a Primary Health Framework in April 2013 that lays out key objectives and requires bipartisan agreement with each of the jurisdictions. (Standing Council on Health, 2013) The framework is still on the Australian Government website,¹⁰ but the signed bilateral agreements were not completed before the change of Government in 2013. This persistent lack of a coherent and consistent approach to national primary health care policy has continued to impede a comprehensive approach to sector partnership gaining serious traction. The consequences of widespread reductions in smoking and the reach of immunisation have contributed to the significant increase in life expectancy since the 1970s. However, this emphasis, and the potential for a greater utility of primary and population health approaches, is not material in the resource allocations to health policy by governments at every level.

Policymaking includes non-decisions, the veto of decisions, reframing or naming a strategy, and the successional replacement of an aspect of an earlier strategy or approach. Lin (Lin & Gibson, 2003) contrasts the difference between rational and political decision-making as an art form, responding to perceived problems that are defined by context which in turn will be differently perceived. This is similar to the ‘muddling through’ categorised by Lindblom (Lindbloom 1959).

1.2.4 ‘Health in all’ policies: a discourse for fundamental health improvement

Healthy public policy, if applied, would be more proactive in recognising the conditions, environments and factors that compromise health and then work upstream to pre-empt the impacts with timely, innovative and strategic responses. A review of the changes in the structures and organisation of health care and health

¹⁰ <http://www.health.gov.au/internet/main/publishing.nsf/Content/nphc-strategic-framework>

policy provides an account for some of the diverse range of interests, and the general lack of consideration of health outcomes in health policy practice.

There are several different measures used to determine health improvement beyond that of life expectancy. These include disability-free life years or levels of psychological distress (ABS, 2013), and the Better Life Index (OECD, 2011), which compares topics of wellbeing across OECD countries relating to quality of life as well as material living conditions. Implementing a healthy public policy approach requires commitment to a review of these measures, or similar, together with multi-sector commitment, and a focus on partnering strategies and approaches at all levels of governments. Establishing these conditions will, arguably, provide the greatest opportunity and authorising environment for mobilising people and communities to reduce inequities and, in turn, improve on the relative numbers of people who live mentally healthy and disability-free years.

There have been several different perspectives on the evidence of the need for a more holistic approach to preventing chronic disease in vulnerable communities (Adler and Newman, 2002; McGinnis et al., 2002; Graham, 2009; Keleher, 2011). These writers have argued the need to focus on more than the promotion of healthy lifestyles and to include policies which improve access to education, housing and employment, and increase social inclusion. More substantively the need for these policy considerations have been analysed by Baum (2002), and more recently by Clavier and de Leeuw (2013b), and in the Canadian report by Fafard (2008). Each recognises the need for policy strategies that require inter-agency and intergovernmental cooperation and engagement with markets, communities and across and between government agencies.

Several limiting factors are converging as market-orientated governments struggle with increasing demand for services, having less resources to provide, and the increasing distrust of governments and bureaucracies in having the skills required to “fix” the problems (Hess & Adams, 2007).

This interdependence of economic, environmental and social influences on peoples’ health is broadly understood in terms of concepts and ideas, but is not evident in application. One long standing exception is that of Finland where a stable approach and universal health policy has enabled the establishment of a national healthy public policy response over several decades. There have been numerous studies of this national application which started as a potential cost-effective response to the economic downturn in the province of North Karelia in the early 1970s. Reviews by the WHO (WHO, 1991) and others have praised the policy and programs, although a significant criticism has been that it has not been well understood by the public. However, there has been a public health impact from other sectors beyond

governments, including the media, private, and community sectors that have respectively developed or promoted ideas that are then financed or supported by national policy or, at the sub-national or local municipality level. As a pioneer in the field, the 'health in all' policies approach was adopted as the health theme in 2006 when Finland took over the presidency of the European Union (Melkas, 2013, Forslin et al., 2012). In Australia, there have been small-scale movements toward 'health in all' policies approaches in South Australia (Kickbush & Bucket, 2010), and to a lesser extent in Tasmania (Tasmanian Food Security Council, 2012).

The position of a healthy public policy approach with reference to health care is represented in Figure 4:

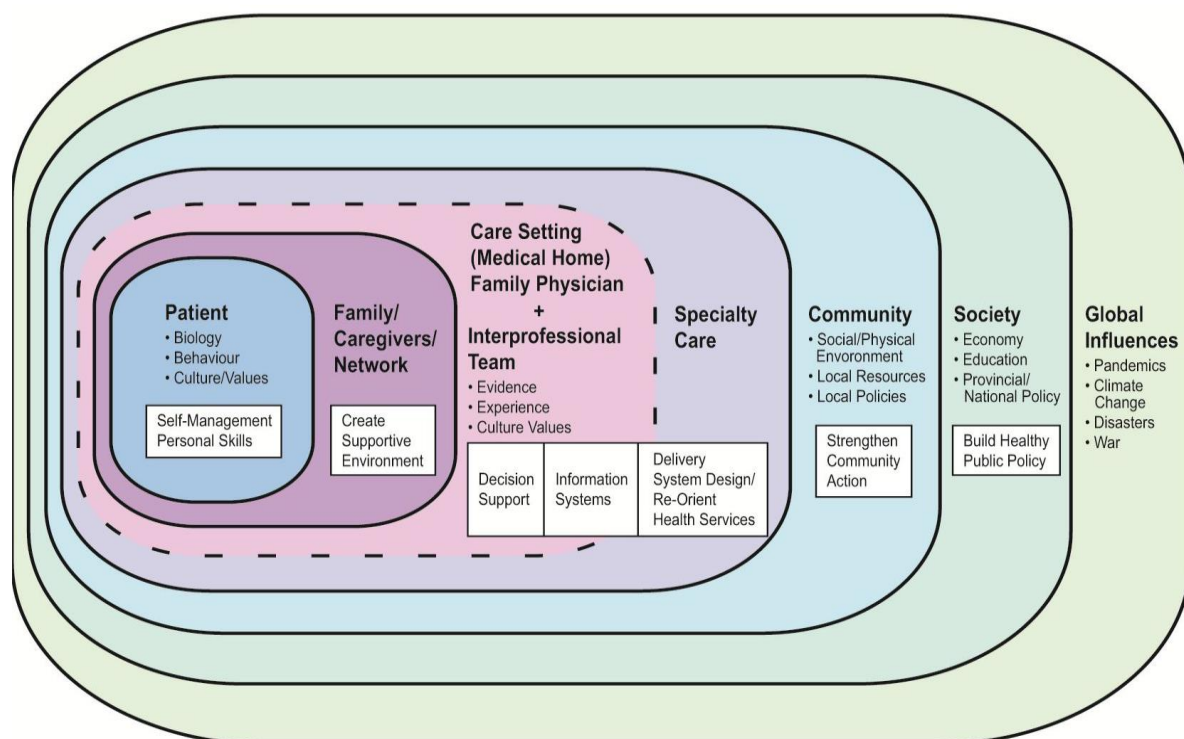


Figure 4 Extract of presentation to the AHHA Roundtable for the 30th Anniversary of Medicare, 30 January 2014 by Dr Stephen Duckett, Health Program Director at the Grattan Institute.

The term 'healthy public policy' was first used in the Ottawa Charter for Health Promotion (WHO, 1986) which was written at the First International Conference on Health Promotion in Ottawa on 21 November 1986. The Charter identified five health promotion areas: build healthy public policy, create supportive environments, develop personal skills, strengthen community action, and reorient health services. These actions were determined as interdependent, but healthy public policy establishes the environment that makes the other four possible. Healthy public policy

is characterised by consideration of the health impacts of particular policy decisions that could result in adverse health consequences. The likely consequence of adverse health impacts is usually long term, and indirectly attributable or unknown, and so healthy public policy signals the intention for policymaking decisions by governments to be informed by a broader range of evidence. The challenge to advance such a health policy approach not only includes multiple sectors, priorities, interests and institutions, but it also requires the acknowledgement of complexity, and facing 'wicked' problems which have no predetermined solutions with adaptive and system-focused responses. A more comprehensive diagram of the healthy public policy approach within the context of the determinants of health is as follows:

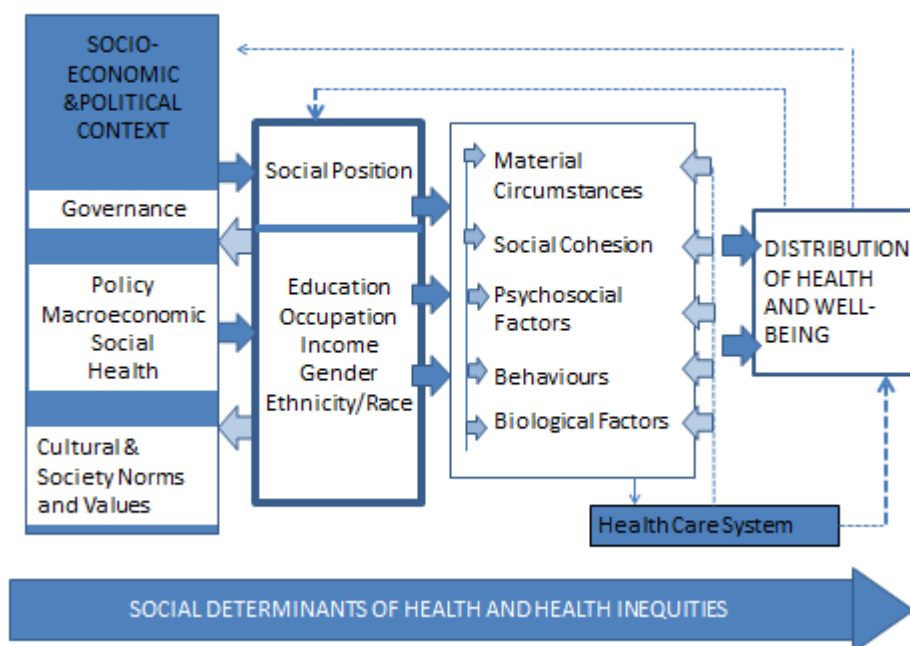


Figure 5 Conceptual framework of social determinants of health, Adapted from (Kickbush & Buckett, 2010 p29)

1.3 Insights from the policy literature

This study seeks to provide understanding of the dynamics of health policy change in Tasmania. There are different ways of conceptualising health policy and the dynamics of change that are associated between the dominant treatment oriented focus to a comprehensive primary health policy that would include healthy public policy and a 'health in all' policies approach.

A comprehensive primary health approach includes the influences of social policy that have been highly contested over the same period, particularly with reference to entitlement (Beland, 2010). Analysis in social policy is, as in health policy, currently focused on the budgetary monetarism policies that cause a requirement for fiscal

austerity in governments at every level. And yet support, and indeed provision, for health and social care remains widespread and relatively stable in affluent countries. The politics centre on the “renegotiation, restructuring and modernisation of the terms of the post war social contract rather than its dismantling” (Pierson, 2001). Where then, can the evidence be informed by the changes that are occurring? The public policy literature provides relevant insights with reference to the various accounts of policy implementation. Howlett et al (1995), for example, noted that successful implementation is affected by the extent of the behavioural change required and the practicalities of what is actually required to change institutional structures. The strength and hold of normative practice and custom within existing institutional structures are underestimated and not fully understood.

The contestability of health policy stimulates the need to better understand the factors that cause change and whether they can be identified and, if so, whether they can be observed? In demonstrating the diverse ways in which health is understood, it is observed that perspectives are driven by ontological assumptions as well as epistemology. This stimulates the need to better understand how new ideas emerge, and how they are developed and gain legitimacy, especially within institutions.

The density of the range of organisations, interests and institutional structure in health and community care raises the question whether this diversity in the types and volume of actors and institutions in health contributes to, or is a reflection of the complexity. The prevention and management of chronic conditions provide a focus for examining the diffused impacts of health policy change over time, because they have taken decades to become the dominant cause of ill health. Chronic conditions need management over time, with intermittent treatment interventions, and the management of symptoms to slow the advance of potential complications. The complexity of health policy change is usefully illustrated by focusing on chronic conditions because they illuminate the challenges of multiple professions, organisations and interactions for the patient and their family, as well as for care providers and policymakers. This raises the question of how the processes and dynamic of change occurs, and whether there are particular subsets of the policy process that are observable, such as the discourse and the development of ideas among particular actors or within and between particular institutions, as well as the structural or other disincentives for change.

In consideration of the understanding health policy change toward a more health promoting approach, and particularly within primary health policy, the more recent ‘health in all’ policies approach, issues of complexity come to the fore. Within the sub-fields of primary health policy there are multiple funding streams and methods of organisation and delivery, and as a result there is less clarity in primary and community health in Australia, in terms of national policy and position, than there is in other aspects of health policy.

The distrust of governments and the increasing tendency to contract and commission services (Considine, 2002, p1), suggests that the literature on network governance could provide a lens for understanding the current policy processes, and implementation in particular. Primary health policy requires multi-agency, multifactorial domains and the need for linkages and cross-boundary working between institutions, together with the challenges to the normative accounts of hierarchy. Networks are said to be the new policy instrument through which goods are created and defined. However, this may not adequately cover the understanding required with a diverse range of relationships both semi-formal and informal, each of which infers meaning, purpose, and differing levels of engagement.

There is a fundamental paradox at stake with what may be described at one end of the spectrum as a 'best practice' view of the policy process that governments are instrumental and follow a defined and structured approach to decision making (Palmer & Short, 2010), while another view sees the policy cycle challenging some of the very premises of governments in terms of democratic process and civil society (Hyde 2008). Increasingly integrated approaches to policy development and service delivery depend on collaboration within and between sectors as well as with communities and the public. Organisational structures, particularly those of Government, are relatively stable and likely to be slow to change. Whilst there are some differences, health organisations are typically predictable with hierarchical structures that are overlaid with the powerful interests of the medical profession. Despite the intentions and best efforts of many individuals, the operating environment for implementing a more 'joined-up' approach to service provision is likely to resist and generally undermine approaches that challenge these structures and norms.

The sub-national jurisdiction of Tasmania has these same features in common with other jurisdictions nationally and internationally in terms of its health and community care services and policy processes. Some features that are particular to Tasmania include the proximity of the actors and institutions given the small population and land mass, a relatively high dependency on federal funding, and the Hare Clerk proportional representational voting system which tends toward stability in party representation and decision-making by State Government.

Having identified that agency interests, structures and institutions, and the dynamics of ideas and communication are all important features of the changes to health policy, it is important that the analytical framework adopted in the study takes account of organisation theory as well as the public policy literature. This broad body of scholarship is diverse both in terms of its methodological foundations and the ensuing analysis. The next chapter will review the literature relating to actors,

institutions and change in order to establish a theoretical framework within which these questions of agency, discourse and legitimacy in health policy change can be analysed.

CHAPTER 2

2 Theorising health policy change

The intention of this research is to understand the dynamics of health policy change. The first chapter introduced the field of health policy, how it is constituted in the health literature, and the features of a fundamental change to a comprehensive primary health approach. The central focus of policy analysis is, as seen here, to understand the complex processes through which actors and ideas intersect with institutions and shape the policy agenda, formal decision-making and outcomes. The following review of the literature is set in the context of health policy change and takes a particular focus on the dynamic processes of agenda setting and implementation and the use of evidence to inform policymaking, as well as the interactions between people and organisations.

The chapter examines the relevant features of several theories that focus on institutions and actors which may be relevant to intentional health policy change in Tasmania. The particular theoretical emphasis sought from the literature is that of agency and interests, the dynamics and concepts of change, and the contribution that institutions play in the emergence and development of ideas. In particular, this chapter draws from the many accounts of institutional and actor-centred theories with a view to explaining how they intersect in the specific historical conjuncture being studied. These various approaches are considered with particular reference to the relative stability of health policy reform, and the slowness of change toward primary and community health focussed approaches.

Institutions, actors and change have been identified as important features in the dynamics of health policy. This chapter reviews organisation theory as well as the public policy literature in order to better understand the ways that ideas take hold and gain legitimacy in a context of the complexity of this subset of health policy that has significant diversity and volume of actors, organisations and structures of communication.

Having considered the theoretical merits of the positivist rational deductive approach and the constructivist and interpretive approaches relevant to health policy, the literature relating to institutions and its capacity to potentially better understand the role of institutional structure is reviewed. This leads to the fourth section, or second half of the chapter which considers the literature on DI in some detail. Each of the new institutionalism theories could provide a useful analytical framework for the study that follows, but the development of DI that emerges from them provides the best insights and explanation because of its particular emphasis on the dynamics of

change and the focus on communication. The review of DI is structured to follow the theoretical insights relative to each of the three key research questions for the study.

The final part of this chapter considers each of the key research questions that emerge from the combination of the policy context and the literature review relevant to health policy change. This forms an analytic framework for the research strategy that follows in the next chapter.

Public policy at its most general includes the interplay of the technical, normative and political processes that determine which issues are prioritised, what are identified as the policy problems, and the evidence or factors that are communicated in order to shape decision-making for implementation by governments. Health policy, as a distinctive subset of public policy, is concerned with the “actions that affect the set of institutions, services and funding arrangements that we have called the health care system” (Palmer & Short, 2010, p23). Primary health policy is a subset of health policy and focuses on the health of individuals and population groups. Primary health policy includes the subset of healthy public policy that has been articulated as ‘health in all’ policies since 2006, and it does this by adopting a broader focus on policymaking that emphasises the conditions for good health across governments and sectors.

Some scholars (Haas, 1992, Wendt, 1987) have suggested that discourse is used to deliberately generate new ideas for action and identity by policy elites and coalitions positively connected through epistemological communities. Haas, for example, argues that the cause and effect of the relationships of complex problems are articulated through the networks of knowledge-based experts, and help frame the issues for debate as well as to identify the “salient points for negotiation”. If institutions can be viewed as the context for discourse then the interaction of new ideas such as ‘health in all’ policies could create adaptation, and indeed new institutions over time. However, the sharing within professional groups can have the impact of re-enforcing interests, which can result in maintaining or reverting to status quo and prevent rather than aid adaptation in practice.

There has been a relative stasis in health policy since the 1980s and the positivist institutionalism approaches tend to explain the lack of change better than the changes that have occurred. The assumptions of fixed interests and relatively immutable structures based on the foundations that have already been laid down are of little help in exploring the contemporary policy making environment. This chapter will argue that a constructivist and interpretive approach is required to explain the dynamics of cross-sector collaboration and systems-based thinking and the potential to observe change. DI will be shown to be particularly helpful in accounting for these

non-positivist features of health policy change, because it tends toward a more dynamic explanation to gaining a normative commitment to ideas over time.

2.1 Rationalist approaches to understanding health policy reform

The literature on health policy change can be broadly accounted for as a set of competing rationalities which are deeply institutionalised. (Lin, 2003, p14) Interests and decision-making are biased toward an historical perspective that draws its evidence from the structures and decisions that have gone before. The dominance of the medical profession, together with the institutional conflicts and constraints in health have been well documented (Palmer & Short, 2010; Baum, 2002) as key causal factors for policy staying rooted in the arrangements for curative care. Richardson (2005) has been critical of the failure of successive Australian Governments to tackle the failures in performance of health policy, preferring to focus on what he suggests are largely the 'marginal and irrelevant issues'.

One illustration of this is the path dependency policy focus on private health insurance that has dominated Australian health policy through successive governments from the 1990s (Boxall and Gillespie, 2013). In France, Germany and the UK, policy has also had a narrow focus. There have been successive policy changes in health from statist regulatory approaches to the loosening of controls and enabling of quasi-market-based approaches, and back again (Hassenteufel, 2010), but with no substantive changes in policy content. The focus everywhere has been managing the financial constraints, primarily focusing on improving the efficiencies of the delivery of health care and transferring costs to citizens wherever possible and politically acceptable. This is characterised in the UK by an emphasis on efficiency and patient waiting times, whereas in France and Germany (where expenditure is reimbursed to the patient rather than directed through a national health service) there has been a policy trend of cost containment.

The establishment of health policy is influenced by key trends and developments in public administration more broadly. The loss of trust in governments, described as 'contemporary disillusionment' by Olsen (March and Olsen, 1986,p342) has impacted on policy reform that is focused more on changing institutions than the underlying consideration of the complexity of policy issues and the policymaking environment. Health and social policy in Australia and elsewhere have been subject to the governance changes in public administration during the last thirty to forty years, and a greater emphasis on partnerships and collaboration. Each of these informs understanding of the drivers and constraints on health policy reform. There has been a resistance to acknowledge and act on the significant burden of evidence that the

major cost drivers are medical procedures that do not substantively reduce disease or add to life expectancy.

Alford and Duckett suggest that this is because of the 'lethal hegemony' of the 'corporate rationalist' interests in evidence from the 1980s, (Boxall and Gillespie, 2013, p67) driven from within governments wanting to increase efficiency and performance, more than from the power and influence of health professionals.

Policy analysis is described as the purposeful support to government decision-making that combines "sophisticated technical knowledge with intricate and often subtle social and political realities"(Fischer, 2003,p2). The literature is broadly categorised within the inductive or deductive theoretical approaches with a further lens of the individual, group or institution provided in a taxonomy of political analysis provided by Howlett and Ramesh (Howlett, 1995,p19). The deductive approaches start from an instrumentally rational frame of reasoning whereas the inductive analysis and theory building is drawn from empirical evidence. However, the typology of regulation, distributive, constituent and redistributive policy types that were identified by Lowi (1972), and revisited by Kellow (1988) illuminates some of the contestability of these typologies in analysis. While Sabatier (1999) asserts that Lowi's typology has "aroused very little interest" in recent years (Sabatier, 1999, p11), redistributive policy is ideologically contestable and subject to the conflicting values reflected in contemporary health and social policy. Stone (Stone, 2002) refers to the 'rationality project' that fails to take account of these underlying differences in societal values, and that governments manage the potentially negative perceptions of a redistributive policy by presenting them as instrumentally distributive. Policies create their own politics and interests and political leaders are 'locked' in a reproduction of repetitive institutional logics that maintain continuity of the economic interests that are served through the existing structures of health care. For example, the 'GP Super Clinics'¹¹ program of the 2007 Australian Labor Government was redistributive, but presented as a distributive policy to be more acceptable to the mainstream values discourse.

The criterion for what determines 'good' health policymaking is inevitably contested and there have been different balances of influence between the major categories of actors that have shaped opinions and tempered the pace of change. The political, technical and cultural, or values-based, competing rationalities identified by Lin and Gibson (Lin, 2003, p14), suggest that 'simultaneous truths' exist side by side depending on the perspectives of particular groups or individuals who may be

¹¹ The GP Super Clinic program was an economic stimulus of capital funding specifically intended to incentivise boost general practice to work with others. The finding of the Australian Audit Office (ANAO Administration of the GP Super Clinic program, 20 June 2013) was critical about whether they provided value for money and any improvements for primary healthcare.

identifiable by profession, positional authority or shared interest. The issues to be addressed, the evidence and the communication of priorities for action are reflected in these different rationalities which may converge or conflict depending on relative power, knowledge and the context. Despite the contestability of health policy in general, most analysts agree that the dominant discourse in health policy analysis is shaped by the ideas and professional norms of the medical professions (Harrison, 2003).

Doctors are known to be “wedded to existing and familiar forms of remuneration and relationship to patients” (Boxall and Gillespie, 2013, p64). This influence runs through the relationship with policymakers, the general public through patients and health consumer organisations, the media and politicians. This ability of medical professionals to shape the health policy debate is akin to what Lukes (1974) described the third dimension of power, where collective forces and arrangements that control political agendas through tacit agreement. While many influences have challenged the medical dominance of health policy including quality and safety, public access to medical information and the increased emphasis on multi-professional care, the traditional role of the medical professions is still defined through the longstanding “status afforded to individual doctors by society and the deeply entrenched cultural systems arising principally from the influence of professional craft groups” (Dowton, 2004). Therefore, any analysis of health change must take account of this discursive power.

The structures of health organisations are an important factor in health care policy development so that the implementation of substantive change is unlikely to occur without the engagement of clinicians. (Berwick, 1994). Institutionally the NHS in the UK, in common with other European countries, describe health organisations as professional bureaucracies (Isosaari, 2011) that recognise specialist knowledge and expertise. Professional bureaucracies are characterised by having strong horizontal linkages, and therefore change is more successfully navigated through influence across peer networks than through the application of formal authority structures. A feature of the professional bureaucracy is that they are oriented to stability rather than to change. The recognition of the informal leadership of health professionals has been referred to as a ‘soft’ bureaucracy which can have gradations of positive and negative impacts.

Health professionals are trained to treat individuals and, at least in a general sense, to treat ill health rather than to work systematically for the determinants or factors that impact on health improvement. This is a substantive difference in professional outlook from those of the ‘in charge’ administrator even if this function is undertaken by an individual with clinical training. In a review of hospital structures in the UK, Bates (Bates, 2000) identified the ‘grid-lock’ that can occur when health professionals undermine managerial power. This can also determine the functionality

between disciplines and professions when one resists cooperation with other clinical subsystems. At its simplest, there are some professions more adequately oriented to collaborative approaches, such as nurses, occupational therapists, public health and general physicians, while others tend more towards maintaining the boundaries of their own field.

2.2 Role of institutions

In the early consideration of institutions, the formal institutions of government and the modern state were mapped and compared within and between countries. The main emphasis was on description, and the assessment of normative arrangements. It is now better understood that the combination and interaction between formal and informal relationships within institutions is an important source of additional information in understanding policy and policy change. Campbell (Campbell & Pederson, 2004), for example, observes that there are as many similarities in the different schools of institutionalism as there are differences. Scott suggests that there are three key analytical elements that demonstrate most clearly institutional differences and the characteristics of how each of these elements. At times one of these features will be observable as dominant and at other times all of the elements will work together (Scott, 1995). This is based on ontological assumptions that underpin the constructs of order and action, the extent to which actors are rational in their approaches to decision making, and what is meant by rationality itself. "Institutions exhibit stabilising and meaning-making properties because of the processes set in motion by regulative, normative and cultural-cognitive elements ... providing the elastic fibres that guide behaviour and resist change." (Scott, 2002, p57).

Social structures have a duality that includes the ideal of culture and belief as well as the rules and structures that bind them. Rules can be up-held by sanctions and most of the explanations of institutions consider the ways in which rules and constraints operate. However, institutions can also provide stimulus and resources and go through change that may be incremental or revolutionary (Kay, 2007). Institutions do not act, but rather provide the context within which the actors find, or establish meaning and purpose and the places where the interactions occur. March and Olsen (1984) broke away from the rational institutional paradigm finding that institutions are neither a mirror of society, nor merely the site for individual strategies.

The 'normative' conception of Scott's pillars is the type most commonly embraced, and it is explored in the observations of political institutions by March and Olsen (1984, p735). They highlight several aspects of 'behaviourism' that moves the attention to that of a 'calculated self-interest' rather than a product of the individuals responding to the obligations and rules that are explicitly laid out. Hecló (Pfiffner,

2007) too referred to an 'inside out' experience of the perspective of the actors demonstrated in a deeply felt commitment to the purposes behind the job, rather than a strictly instrumental attachment to doing it.

Bell (2002, p4) describes this as an analytical shift from the state and its formal organisations of government, to a more 'society-centred' focus that emphasises the informal distributions of power and the embedded nature of pressure group politics. The loss of public confidence and the contemporary disillusionment with governments appears to be more focussed on the institutions and actors within them, than on the ideas and policies they produce (March & Olsen, 1986, p342). This is expanded to consider the sorts of institutional change that could occur for institutional relationships that would support the capacity for governments to make decisions and take action. If institutions, for example, shape the power and preferences of actors, then the "organisation of policy making affects the degree of power that any one set of actors has over policy outcomes" (Hall, p19) using the power of treasury departments as illustrative. This has been a generally held popular view, but March and Olsen (1986) argue that contemporary governance has become too complex for citizens or politicians to understand or influence the processes. The interdependencies between societal discourse and the actions and responses of actors and actor groups inside the institutions of government have boundaries that are more permeable than ever before. This "oscillation", they (March & Olsen, 1986, p364) conclude, is better for society because the tensions between "contending concerns, demands and values [is better than that of] procedures requiring a permanent resolution of them.

Powell and Di Maggio (1991) favour the cultural-cognitive explanation of how institutions matter and shape outcomes. This suggests that there are 'templates' and 'scripts' for action and the roles that arise as common understandings are developed around the actions of particular actors. Di Maggio and Powell emphasise that this can be extrapolated to wider belief systems and cultural frames. Legitimacy is conferred through various means including the legally sanctioned, professionally authorised or culturally supported means.

Macfarlane (2013), whose case study on institutional health care change in London considers the role of institutions, suggests that health care change is continuous but on a relatively small scale. Whole system change – and therefore large scale policy change such as that to more systematic health promoting approach – is more difficult, less common and harder to sustain.

Macfarlane summarises Scott's pillars on page 1 (Macfarlane F, 2013) as:

- Regulative – the laws and contracts which stipulate what *must* happen
- Normative – the assumptions and expectations about what *should* happen

- Cultural-cognitive – the ‘taken for granted’ scripts and mental models about what generally *does* happen.

Change is mirrored by the pillars with three types of attempts to alter them:

- Coercive – altering the rules or regulations
- Normative – changing the expectations
- Mimetic – copying a model of best practice.

In a paper to the International Sociological Association in Montreal, Wendt (Wendt, 2009) considers how health care systems are institutionalised, and in particular how relatively uncommon it is for consideration to be given to service utilisation and health and social outcomes. This study is concerned to understand more of the cognitive barriers to structural change. These latter approaches would take into account the relationship between health care organisations and social behaviours, and provide insights about the extent to which service providers respond to the needs of their patients. Gomez (2012), considers the system-level impact of institutions thinking, like MacFarlane, and finds that it can help explain the combination of influences that occur both internally and externally to create change. In contrast, only looking at the specific institutions or the specific different actor groups is insufficient to explain the change.

There are a range of perspectives on the role of actors and institutions that have been considered in this and the previous section, revealing a complex and contestable ‘soup’ (March & Olsen 1989; Stone 2002) within which to understand the dynamics of health policy change. The next section will develop the review of the literature relevant to health policy change, particularly in the context of primary health policy with multiple interests and perspectives, and a diversity and volume of institutions and actors.

2.3 Understanding critical approaches

There is a greater complexity to health policy once it is applied to health more broadly than the acute treatment end of the spectrum. This includes sub-acute care, hospital in the home, palliative care, hospital avoidance and long term care services in addition to primary and community sector services, which are more of the focus of this research. When policy consideration is given to primary and community health services, the number of actors and interests significantly increase, and because of the diversity of services and the ways they are organised there is little heterogeneity and greater visibility of the complex social and economic issues. One characteristic of the associated broader health policy process is that its evidence is usually drawn

from systematic review findings resulting from policy and practice decisions. This is because the community and primary health environments are multi-professional and sectoral and the criteria used for clinical research do not adequately address the contextual information. This is needed to assess the social and political factors that may impact on individuals and communities unintentionally exposed to policy interventions.

While healthy public policy is fundamentally rooted in partnership and collaboration, the interventions and strategies generally take time and so it is difficult to establish results that have legitimacy within the dominant health policy discourse and fit within the timeframes of government terms of office. As noted in Chapter 1, Finland and some of the other northern European countries are among the small number of places which have evidence over decades of continuous and focused policy activity.

The theoretical approach using the advocacy coalition framework that Sabatier established (Sabatier, 1993) offers a useful predictive model of policymaking by highlighting the relative influence of policy ideas that are established by competing groups of actors that are members of related subsystems. The policy process, according to the advocacy coalition framework, is driven by actors inside and outside of government agencies, and can include academic interests and policy researchers and activists in community sector organisations. The range of actors within government agencies and their various inter- and intra-professional interactions creates significant additional complexity when they are seen as 'nested' in the external policy coalitions that compete for the progress of their particular objectives. Policy capability has, arguably, been limited because of the competing frames and contested place of health policy in the broader public policy arena where the bureaucracy, and therefore the policymakers at the political and the senior agency level, are criticised for not getting performance and efficiencies under control (Gleeson et al., 2010). This could provide a rationale for why the focus of health policy has been driven more by market-based approaches than by fundamental considerations of strategies to promote more effective health outcomes. There have been international policy elites that have active interest in the social determinants of health and formal and informal organisations have been established, such as the People's Health Movement¹².

The actors in the sphere of healthy public policy are more diverse. There are the interests of the health professions to consider, but they are only one part of a mixed bag of advocacy organisations, different levels and agencies of government, faith-based and community sector organisations, academics, community development practitioners and health promotion professionals. In addition, there are the private

¹² See People's Health Movement and international voluntary organisation aimed at promoting the 'health for all policy' Millennium goals of the Alma-Ata in 1978 accessible at <http://www.phmovement.org/>

interests of corporations including fitness, food and nutritional supplements industries. (Baum, 2002).

The literature of Baum (2002), Marmot (2004), Keleher (2004) and Palmer and Short (2010) are drawn from to describe the development of the 'new public health' and with particular reference to the establishment of the policy paradigm for 'health in all' policies. The stages approach to policy analysis is too simple a heuristic (Bridgeman & Davis, 2000) when it is applied to the complex processes of problem-identification and agenda-setting with the wide range of interaction and influences between actors and institutions. Kingdon's 'streams' approach (Kingdon, 2003) is useful in considering the concurrent activities of policy ideas development, problem identification, and the priorities identified by the public and interests that form the third 'political' stream. Issues that are identified publicly may not necessarily be converted into political issues, but others that are the material interest of powerful interests or institutions may return to the policy agenda because of this.

Multi-layered and multi-agency, as well as multi-sectoral activity makes a more complex institutional environment (Hageman and Bogue, 1998). There are several countries that have a relatively simple single layer jurisdiction such as the UK, together with New Zealand and many European countries. However, in Australia, like the USA and Canada, the federal system provides a more complicated set of arrangements. The sub-national jurisdictional governments have central agency interests of the premier departments as well as responsibilities of education and health service policy and service delivery. Health policy is developed, funded and managed at national, state and local government levels and so there are many obstacles to policy innovation, opportunities for veto, as well as confusion as to where decision points sit. Some places, like Finland, have had a long term coherent commitment to a primary health and, more recently a 'health in all' policies approach, described in detail by Konu and Viitanen (2008).

Building on this, in a review of the literature regarding actors and institutions relevant to the changes in health policy, Lin (2003) summarises that it can be viewed as a set of competing rationalities. The cultural rationality reflects the values and expectations of policy which is contested by the dominant positivist scientific view. The technical rationality is the application of evidence to inform policy and the establishment of a fundamental change in health policy that requires the legitimacy of diverse methodologies and sources of evidence. The political rationality is where the legitimacy for change is created through the participation and influences of policy processes, as well as by commentators and interest groups.

Some scholars have suggested that discourse is a factor in the generation of new ideas for action and identity, and that this is developed by policy elites and coalitions that are positively connected through epistemological communities. The interests around the health policy discourse of 'health in all' policies has, for example, been

established through national health policy development over three decades in Finland (Melkas, 2013). National governments in other countries have not had the coherent interest in new health policy discourse, rather it has been developed by policy actors, networks and policy elites. Sabatier and Jenkins (Sabatier, 1999) would describe this deliberative discourse within networks of interested policy actors as the advocacy coalitions attempting to pull the ideas into policy action at the local level. There is also a connection with the policy entrepreneur identified in Kingdon's streams model, whose role singularly or collectively is to use discourse as the resource to legitimise ideas, and to successfully communicate them when the 'policy window opens' and an opportunity for change occurs.

This exploration of the policy literature has demonstrated that fundamental health policy change requires change in the discourses that shape and influence interests. There needs to be a wider range of non-traditional (such as the social dimensions of health) deliberation established within the health policy debate.

2.4 Discursive Institutionalism

The consideration of relevant theoretical approaches to health policy now moves from the institutional and actor centred literature to the literature of DI and its capacity to shed light on the change that underpins the shift to a broader focus. This section of the chapter reviews the distinctive features of DI as a theoretical approach to policy analysis that combines the consideration of actors and institutions as well as the observable processes of ideational change. DI is considered at some length because it is applied as the theoretical lens to analyse the explanation of the dynamics of health policy change. Healthy public policy requires an ideational shift among the decision-makers, and a willingness to accept the complexity of multiple sets of actors and institutions. The following sections are each aligned to the key research questions for the study, and considered in the same order. DI gives theoretical traction to both the construction and the consideration of ideas, as well as acknowledging the role of institutions and how each of these factors is mediated through discourse in a specific historical conjuncture.

DI is variously described as constructivist and ideational, and emerges as a consistently distinctive theoretical approach to institutionalism that sees interests as social constructions, and emphasises the development of ideas. It has the capacity to provide explanation of, and offer greater potential insights into, change, particularly as it occurs endogenously. The seminal writers are Colin Hay (Hay, 2001), John L. Campbell (Campbell and Pederson, 2004), Mark Blyth (Blyth, 1997) and Vivien Schmidt (Schmidt, 2002). Hay (2008 p2), emphasises that because of the particular motivation to understand change, the roots of DI are from Historical Institutionalism, though it may also have more in common with organisational theories of change. Historical Institutionalism, together with some other new

institutionalisms, is well placed to provide explanation of changes that occur because of exogenous shocks, changes in conventions or path dependencies. However, it is less able to provide analytical purchase on questions of complex endogenous institutional evolution, adaptation and innovation.

Vivien Schmidt is a major proponent and introduced the theoretical policy framework of DI to provide an explanation for the policy processes in which ideas and discourse shape change. The following review starts with an explanation of how DI builds on, and differs from the earlier theories of institutionalism to be what Schmidt describes as the 'fourth pillar' (Schmidt, 2006, Schmidt, 2010c). (see Figure 7)

DI is referred to as the fourth 'pillar' (Schmidt, 2006) in this approach with rational choice, Historical and Sociological Institutionalism having been established theories of New Institutional policy analysis. These theories are bounded by their common interest in institutions, but they each have different emphasis in explaining the structures and incentives of policy analysis, and indeed the nature of institutions.

Rational Choice Institutionalism assumes rational actors with fixed purpose who deductively use institutions to further their self-interest and reduce change, and could be analogous to the dominance of the medical model discourse.

Historical Institutionalism is more focused on the rules, structures and procedures of institutions that have been laid down through the consequences of previous events. This could provide an understanding of the significance of the challenge to changing the dominant health policy focus on hospitals that has been secured deterministically through events over time as "regularised patterns and routines" (Schmidt, 2010a,p2).

Sociological Institutionalism focuses on the culture, norms and meaning systems that permeate organisations and set the context for action. The perspectives from Social Institutionalism could explain the macro-patterns of normative behaviours within health policy to maintain the continuity of focus that already exists. However, it is less able to explain how norms are created and change.

| | Rational Choice Institutionalism | Historical Institutionalism | Sociological Institutionalism | Discursive Institutionalism |
|---|---|--|--|--|
| <i>Actors</i> | Behaviour of rational actors | Structures and practices | Norms and culture of social agents | Ideas and discourse of sentient agents |
| <i>Explanation of behaviours</i> | Calculation | Path-dependency | Appropriateness | Communication |
| <i>Institutions</i> | Static – continuity through fixed preferences, stable institution | Static – continuity through path-dependency interrupted by critical junctures | Static – continuity through cultural norms and rules | Dynamic – change (and continuity) through ideas and discursive interaction |
| <i>How stasis is maintained</i> | Entrenched interests | Institutional obstacles and constraints | Cultural ‘blindness’ can stifle innovation | Obstructive views are expressed |
| <i>How change can occur</i> | Coalitions, use of power and interests | Alliances, position and blocks | Expression is anticipated and new norms established | Emergence of ideas in coordinative or communicative spheres |
| <i>Explanation of change</i> | Exogenous shock | Exogenous shock | Exogenous shock | Endogenous process through background ideational and foreground discursive abilities |
| <i>Recent innovations to explain change</i> | Endogenous ascription of interest shifts through RI political coalitions or HI self-reinforcing or self-undermining processes | Endogenous description of incremental change through layering, drift, conversion | Endogenous construction (merges with DI) | Endogenous construction through reframing, recasting collective memories and narratives through epistemic communities, advocacy coalitions, communicative action, deliberative democracy |

Figure 6: The four new Institutionalisms
Adapted from (Schmidt, 2010a, p5)

DI is distinctive from the early theories of institutionalism that see institutions as relatively static (see Figure 6) and describes change occurring as a result of external triggers and causality. DI recognises that change can start from the inside, and focuses on the dynamic agency of interaction and action in context (Schmidt, 2011c). Institutionalism has generally revealed the importance of political institutions in analysis, but it is DI (the fourth pillar) that brings to life the account of change itself, drawing on insights and analysis already made in the other theories of institutionalism, and bringing this together with consideration of when and how new pathways of policy or strategy are forged.

Significantly the analysis of DI explains change as endogenous, constructed through the reframing of ideas and narrative epistemology, whereas the other theories tend to explain changes as exogenous or external. While most institutional scholars have identified there is a potential for situational agency, the theories of institutionalism more broadly continue to rely on a stasis. DI is more specific about the processes of agency within institutions and reflective of the impacts and interactions these bring to bear. Another characteristic of the theory is that it can draw from the other institutionalism theories, because it is intended to add a dimension to them, not operate in isolation from them.

The DI approach will be used to explain characteristics of the power that was a feature in initially getting the primary health policy plan onto the agenda in Tasmania. There was a gradual realisation of rural workforce shortage that was impacting on local cultural norms because of the increased percentage of locum staff required to maintain inpatient facilities. This threatened the stability of the informal institutional rules, including local relationships within the communities served, and gained political interest and support to be included in the agenda for health care reform. These same features of workforce shortage and the use of locums were possibly a contributory feature of resistance and slowness to change at the local level.

More broadly, an actor-level approach that focuses on policy discourse is relevant to this study because it allows for an explanation of the variations of acceptability of particular strategies within one sub-national jurisdiction. This suggests that relationships and policy discourse are both important factors for understanding what matters and what happens. A comprehensive primary health approach is more than redistributive policy, it requires multi-sector and multi-professional communication between actors and their respective institutions. This study is concerned to highlight the dynamics of new ways to conceptualise health and therefore to focus on the discourse rather than the differences between interests or position.

Schmidt's argument is that whilst institutions are important in providing the context, DI demonstrably moves beyond the narrower forms of institutionalist thinking. DI seeks to identify what is common in everything that focuses on ideas and discourse. It is therefore not contingent on the path-dependency, rationalist or cultural framing

of the other institutionalist theories. DI goes to the culture of change itself in constituting political action as the juxtaposition of ideas with discourse and the interaction of many actors in this. It is capable of accommodating change regardless of whether it emanates from persuasion and debate, the construction of interests and values, or the dynamics of historical change. As well as Schmidt, there are several scholars whose focus is also on ideas and institutions. These include Blyth who refers to the ideational turn, and Hay who refers to both ideational institutionalism and constructivist institutionalism (Hay, 2008). All these approaches involve discourse analysis, which has a strong position that resonates within the post-modernist approaches of Fischer with the 'argumentative turn' (Fischer & Gottweis, 2013) and Dryzek's deliberative democracy which provides analysis of the 'creations of reality' constructs. Thus, DI draws on the earlier tradition of Sabatier's advocacy framework that takes a further step to describe how groups of ideas are shaped by coalitions of policy actors (Sabatier, 1993). DI provides a framework to theorise about how the ideas and discourse translate to action, despite or in association with the explanations of interests, dependencies and culture as obstructive constraints. It is these strengths that lead to it being used as the key theoretical approach in this study.

2.4.1 Agency and interests

DI outlines the explicit utilisation of an epistemology based on stories or narratives – the 'ideational dimension' – that draws out the interaction that creates legitimisation between the relevant actors. The actors can be decision-makers, politicians, interest groups, the media or the general public. The purpose is to develop or establish policy, or to implement action. There is a requirement for an internal consistency that marks out a legitimate alternate discourse to the dominant one. This is the conceptual construction, the idea that something new or different could be done. This is coupled with a normative function that makes the case that something different to the dominant discourse should be done. Tracking the journey of where ideas emanate from and where the discourse occurs is one way of showing why ideas may succeed or fail. But while some ideas and discourse tend to reinforce existing realities, only some promote change. The ideas can be formed at three different levels of policy, program or philosophy, although Schmidt identifies that each of these may be difficult to distinguish separately (Schmidt, 2010c,p7).

The 'philosophy' level refers to the deeply held world views that is consistent with the 'deep core' of beliefs referred to by Sabatier (Sabatier, 1993). These more deeply held views are more likely to change slowly, and could hold back the implementation of new program ideas, even if they appear acceptable. At the macro- level, this is important in the context of the policy movement to a 'new public health' discourse and it could also be a useful explanation of the acceptability or legitimacy of health policy changes at the micro- level of the experience of the private patient. For

example, it is widely acceptable that people should choose and give their consent to a care trajectory, but there is an underlying philosophy that the health professional will have the best idea of what the choice in action should be. This puts the broadly acceptable philosophy of 'patient centred care' at odds with the program and policy level practice.

The discourse itself could exert the causal influence through the promotion of change. To use the patient-centred care example further, this could be through the representation of the idea of the patient at the centre of the decision-making for programs and policy. Alternatively, the discursive process of conveying the ideas of the 'empowered', or 'informed decision-making' patient within institutions and policy networks could be the causality of change in practice. In order to observe change in health policy toward a healthy public policy response, a dominant discourse needs to be embraced into community sector organisations and the polity as well as within policy communities inside of governments.

The second dimension is the interactive perspective which is critical to the process of shifting the ideas to action itself. There are two component parts to this process, the first of which is coordinative and explains the development of a common language with which policy can be established and developed. The second part is the communicative function which is that of persuading the general public that the policy discourse and approach is both needed and required. The coordinative function is generally internally driven and the communicative function is about 'selling' the message.

The coordinative function is internally driven by the policy actors, who generate the ideas that form the bases for action. 'Internal' in this context is not only conceived of as being within governments, but rather it is the epistemic communities or the individuals who come together as advocacy networks or coalitions. The establishment of a healthy public policy approach in Australia, for example, could arguably have been built through the international narrative epistemology that the Southgate Institute at Flinders in SA have been active in through the World Health Organisation's work on the social determinants of health.

The communicative sphere of DI is more public and political, where the emphasis is on the use of ideas in the persuasion of the public, and often through electoral politics and the creation of public opinion. It is the means through which the public discourse is established and overt political support is given from government and from other actors in the political sphere.

The ideational analysis is described by Parsons (2004, p48) as providing "claims about the description of the world, causal relationships or the normative legitimacy of certain actions". There are three types of ideational processes that loosely

correspond to Kingdon's three streams approach to problems, policy and politics (Kingdon, 2003) as follows:

- ideas as understanding of policy issues (the problem stream)
- ideas as assumptions that guide the development of alternatives (agenda setting stream)
- ideas as framing to legitimise particular decisions (the political stream).

In summary, actors have agency and the extent to which this is deliberately applied to establish or to veto new ideas is situationally dependent. The discursive processes of interactions create, at least, incremental change, and the actors are instrumental in framing and legitimising the choice of action to be taken.

2.4.2 The dynamics and concepts of change

If institutions can be viewed as the context, the carriers of ideas and collective beliefs, then the interaction of new ideas can create adaptation and, indeed, new institutions over time. The Rational Choice Institutionalism approach presents the greatest sticking point for this proposition because it would force the acknowledgement of assumptions that are the foundation of preferences and institutional incentive structures. The adoption of new ideas can account for changes that do not fit with predictable rationalist interests or structural factors or historical paths. DI may, therefore, be particularly helpful in accounting for the change in health policy toward a healthy public policy approach because it does not involve significant short term financial investment, rather it is more about a normative commitment, which is why the rationalist explanations are less relevant. There is a tipping point when ideas are legitimised through internal processes of discursive action that may have external reference point. However, they are not only driven from the 'exogenous shock' to the otherwise equilibrium of the institutional state. It is the interactive processes of discourse that is often implicit, rather than explicitly described in the literature.

There has been some explanation of the nature of ideas so far, and of discourse and the ways and the levels in which each of these can be framed. The context of institutions is also important because it is through these arrangements that discourse may, or may not be advanced. The institutional arrangements can determine who talks to whom about what, in what circumstances and when this occurs.

There is a difference between governance arrangements that channel ideas through a single authority and those that have multiple means of representation and authority. In unitary polities there will be a smaller number of policymakers who are

likely to be government or academic actors who generate the policies that are then proselytised to the broader public by political leaders who seek to establish the public legitimacy. In countries this is observed where there is a majority representative institutional arrangement of government and policymaking like the UK and France. The public discourse tends to be elaborate and sophisticated and can be very drawn out.

Countries that have multiple authorities or compound polities, such as the USA, Australia and Canada, demonstrate a discourse among the policy actors in the coordinative sphere that tends to be much more elaborate than the discourse with the general public. This means that the communicative discourse to the general public in Australia is more complex. In the sub-national jurisdiction of Tasmania that is the focus of the case material in this study, there is an additional political arrangement of a proportional representative system that adds a further opportunity for dispersed governing activity. There are features of compound polities that are worthwhile exploring further to potentially understand the changes in health policy that include multiple actor's networks and weak organisations. All of these examples emphasise coordinative discourse, and the need to establish cross-agency cooperation rather than the more public communicative processes.

The communicative discourse is described by Schmidt as 'thin'. (Schmidt, 2006, p11) It is characterised by generalisations that avoid sharing any of the detail of compromises that will have occurred in the communication with the policy actors in private. An important component of understanding this aspect of the coordinative and communicative spheres of DI is that it is more difficult for the compound polities to encompass the views of all societal groups because of power and legitimacy in broadly sociological terms. For example, women, unemployed young people, migrant and refugee communities, casual workers, and so on, are likely to find it more challenging to get their voices 'heard' in the complex arrangement of multiple policy actors and authorities.

The institutional arrangements may explicitly, or more often implicitly, because of cultural norms and historical arrangement, exclude people and communities from the discourse. This is important in the consideration of a broader health policy that has an explicit component of addressing avoidable health inequities, and enabling people and communities to have more power and control in their lives and decision-making.

2.4.3 The emergence of ideas

The people who carry the ideas and articulate them can be political leaders, policymakers, party leaders, senior staff in public administrative positions, policy entrepreneurs, service leaders, media, interest groups, community sector organisations and any other opinion makers. The agents, or 'carriers' of the ideas will

generally fall into either the coordinative sphere of discourse that occurs among policy actors and networks, or the communicative discourse which will be more public and involve political actors and the public. The policy actor exchanges will include contesting the ideas as they negotiate for the legitimacy of particular aspects, creating new frames, and deliberating and reaching agreement. Some scholars point to a difference between persuasion and 'bargaining', although this is problematic when it is possible to argue and contest a viewpoint that is authentic and consistent. However, when the discourse of ideas is in the communicative public sphere, in particular, it is possible to include spin and to obscure the truth.

This is where the policy analysis broadens to considerations of power and democratic process. Bevir and Rhodes (2003) for example, consider the narratives that New Labour used in the UK Government under Prime Minister Blair to change the 'web of beliefs' about work and welfare in the late 1990s. They were able to integrate the former Conservative Government emphasis on efficiency of government through privatisation and markets to one focused on 'joined-up' government with networks of trust between the public and private sectors.

It may be argued, then, that the agents for health policy change come from 'epistemic communities' of loosely connected actors who share cognitive and normative ideas and interests. The common interests are for health improvement generally, a commitment to addressing inequities and to focus on the determinants of health. These agents for change may be in government and academia and they are likely to also come from social movements and civil society. Keck and Sikkink (Keck M, 1998) highlight the importance of transnational and cross-border work over time that includes international social activism for human rights, environmental protection and the reduction of violence against women. Policy actors in the active development and propagation of ideas are sometimes referred to as 'entrepreneurial actors'. These groups are generally coalitions or communities of actors who share meaning and would, with relevance to this research, be characterised by the health promotion activists – for example, members of the international networks of 'health promoting hospitals', 'healthy cities', the 'peoples' movement for health'.¹³

It is useful to more closely examine the dynamics and, potentially, continuity of change through the treatment of ideas in DI. Are there, for example, particular circumstances in which ideas make the causal difference in change, and if so, is this significant? Discourse in DI is about the ways in which interests can shape and redefine norms and practice, rather than being a reflection of historical explanations. This could include the ways that actors in an institutional context recreate cultural norms, rather than being shaped by rational calculations that define the institution. But it is important that the ideas are not viewed in isolation or else they risk being

¹³ Each of these are international networks of policy actors including citizens and community sector activists, academics, public sector leaders, health professionals and policymakers.

without context and perceived as part of the post-modern approaches to critical thinking.

Discourse in DI draws from the three new intuitionist approaches, but can be problematic if it is too deterministic. As Schmidt indicates (Schmidt, 2006, p12), the scholar can see ideas everywhere in the same way that the rational institutionalist sees intentionality and the sociological institutionalist sees culture. Most importantly, Schmidt reminds us, “stuff happens” and the processes of change can be recognised as often unconsciously established without any clear strategies or intent. In seeking an explanation of any particular point of causality then, it is useful to consider when the change can be attributed to the ideas and the process of discourse, charting new institutionalist pathways and the reconceptualization of ideas. This would be distinctly different in explanation to the attribution of the causality of a particular change being a reframing or reflection of the existing institutional constructs. The point of distinction with DI from the other new institutionalist theories is potentially an important factor to take in to the closer examination of the case studies in the later chapters of this thesis. While it may be difficult to identify the conception of ideas as a separate identifiable difference, it could be valuable to assess through detailed case analysis whether discourse is what is serviced to reconceptualise health policy to a broader account of the social determinants of health.

2.5 Toward a theoretical lens for the study

This final section of the chapter provides the bridging point for the research between the problem, the context, the intellectual analysis of relevant literature and the research application that follows. This study is informed by an inductive research design based on case analysis that is used to contribute to the broader theoretical debates concerning the theory itself as well as the health policy process and the dynamics of health policy change. This research is not conducted in a vacuum but rather it is informed by relevant theoretical debates in the health policy and public policy literature. What is helpful is the combination of analysis of the discourse between actors and interests, the complexity of multiple interactions with significant volume and diversity of actions, competing policy frames and the immutable forces of institutional stasis, and, most importantly, the attention given to the fundamental processes of change within the institutional context.

Having reviewed the relevant public policy literature in the consideration of the changes in health policy toward a more holistic approach, the DI literature in particular provides insight to establish the following core research questions:

- How are policy discourses constructed in the coordinative sphere?
- How does the diversity and volume of actors and institutions contribute to complexity?

- How observable is the dynamic of change?

DI provides a useful theoretical lens because it includes features that are of specific relevance such as the shaping and interactions between people and organisations, developing policy legitimacy within the coordinative sphere, and an explanation of the observation of dynamic change. DI builds on a rich history of organisation and policy studies generally (see Figure 6). This is especially at the boundaries between the cultural and the cognitive features of sociological institutionalism with DI. Stone argues that public policy is about 'communities trying to achieve something as communities' (Stone, 2002, p18), and that the use of metaphor and narrative is a potential opportunity to challenge the natural laws of social behaviours. Several other scholars (Stone, 2002, Fischer, 2003, Dryzek, 1994, Di Maggio & Powell, 1991,) have been influential in the development of ideas and institutionalism. The focus on discourse, complexity and the observation of the dynamics of change are the three critical building blocks of DI and are most suited to an analysis of primary health policy.

The next chapter develops this thinking further by taking DI as the theoretical lens through which the methodology is applied to the case study approach. This will provide further detail for how the approach is underpinned by a research philosophy and the strategy applied to how the data is gathered, organised and ordered for the case studies that follow in Chapters 4, 5 and 6.

CHAPTER 3

3 Methodology

This chapter describes the approach adopted in conducting the research and in particular how the dynamic interaction between actors and institutions and the discourses of policymaking were analysed. DI is mainly about the theories of discourse and institutionalism, and provides an explanation of change, without much yet by way of scholarly literature on its methodological application. This study, therefore, contributes to an early application of the theory to case study material. The intention of this chapter is especially to identify the presuppositions that underpin the research, to explain the research strategy and its application, and to identify the features and limitations of the design.

There are implications for how the constructivist and interpretive epistemological and ontological assumptions are applied to the observation and study of the case material in the context of DI, and these are explored. Following on from this introduction to the research philosophy, the rest of the chapter gives an explanation of the research strategy and a summary of the design of the entire project.

The research closely examines and interprets formal and informal documented material from the period between 2006 and 2010 relating to the Tasmania Health Plan. In this respect it follows a broadly traditional case study approach. The case studies assume the interpretive tradition that is based on a subjective epistemology and an ontological belief that reality is socially constructed. The reflective analysis of the material collected was constructed on this interpretive basis in order to inform and assess the understanding of policymaking in practice (Yanow, 2000). This approach has been selected to present a particular focus on the internal institutional development of the ideas and discourse to construct a primary health policy. The author is a participant-researcher and held a senior position within the lead organisation that is the subject of the study. Particular consideration is given to the way that this was treated and managed.

The cases are presented in three separate chapters of interrelated and distinctive themes and are organised within each chapter using a taxonomy that enables a dissection of the policy process relevant to the research questions. As well as being a participant-researcher, the author has engaged in extensive fieldwork, has collected a comprehensive range of the draft documents, notes and by-products of the relevant time period to provide appropriate contextual material, and has undertaken deep reflection on the subject matter.

The first section of this chapter considers the analytical lens that DI provides for the case study methodology, followed by a section on the research philosophy behind it,

then a description of the case study strategy. The fourth section outlines the content, volume and range of material collected, and how the range, subjects and types of documents were organised and sorted into themes. There is a depth and breadth to the data enabled by the access the author has that provides the particular observation of complexity. The fifth section describes how the methodology was applied to analyse the themes and to sort the documents and data into different groups that became the case chapters for the study.

The closing sections of the chapter describe the limitations of participant-research and especially the role and responsibilities of the participant-researcher with particular reference to the interpretation in this study that would not otherwise be possible between people, institutions and processes, and offers a critique of the limitations of DI.

3.1 The analytical framework

Chapter 2 noted how DI is distinguishable conceptually from the other institutionalist theories in that it is a

“[...] framework to analyse endogenous agency and to explain the dynamics of institutional change (and continuity), able to show how, why and when political economic actors may (re)shape their macro-historical institutions and (re)conceptualise their strategic interests and more. [This] is because it looks more closely into the timing of change, whether for policy, programmatic or philosophical ideas at critical junctures or incrementally; and into the agents of change by focusing on who conveys the ideas how and where through interactive processes of discourse situated in both the meaning-based frameworks of communication within which agents exchange ideas through discourse and the structural frameworks of power and position in which agents act”. (Schmidt, 2011a).

The challenges are to develop a framework through which the fieldwork can be explained. For example, why some actions are layered on top of each other while others seem to re-present or reinterpret what went before by changing the name and slightly modifying the form? The distinction of the DI approach is not the approach to observe and understand change in terms of a particular juncture, action or revolution. Rather, change (or continuity) is seen in DI as evolutionary, and it is within these times and processes of change that the attention to observation is given. What were the motivations behind different policy actions, and how were these decisions devised and articulated by the actors responsible? What were the different interest-based positions and how were these accounted for by the actors' own accounts or the context within which they calculated their stance? What were the actions and activity required to establish the legitimacy or acceptability of a

particular action, and how do the respective actors understand and articulate this activity?

Whereas the other institutionalist theories would seek to observe the processes of layering, drift or conversion from the outside, DI seeks to observe the ideas and the discourse at different levels of generality and granularity, from the inside out. Programmatic ideas are different from the more deeply held values and philosophical ideas that frame the policies and programs. Thus DI provides a framework to analyse the content of change over time, and in this way is highly relevant to this study that seeks to make generalisations about health policy change over decades, from the observable actions within a sub-national jurisdiction implementing health policy change over a period of three years.

Schmidt (2008a, p5) makes the general case for DI as an all-encompassing methodological term for approaches that focus on ideas and discourse. This is further explained as:

[...] the ideas through which sentient agents conceptualise their actions and/or the discourse through which they generate, convey, deliberate and legitimate those ideas according to a logic of communication within a given meaning context. Through DI we can gain insight into why institutions change (or continue) by focusing on political actors' substantive ideas about what they were doing and why they altered their practices (or not), and on their discursive interactions regarding who spoke to whom in the process of articulating those ideas and persuading others to change their ideas and action (or not).

A further distinction that is important in terms of the conceptual application of DI to the case study method is that of the 'background' and 'foreground' distinctions, firstly in terms of the ideas and whether they are drawn from the 'policy, programmatic or philosophical ideas' (Schmidt, 2008a). Policy ideas could be described from Kingdon (2003), or Hall (1989) as the programmatic ideas or beliefs that underpin them, such as the 'policy paradigms' (Hall, 1993). Alternatively they could be the more fundamental philosophical positions that are described as 'deep core' in Sabatier's Advocacy Coalition Framework (ACF) (Sabatier, 1993) or that underpin the 'deliberative democracy' of Dryzek (1994). The ideas may be cognitive or normative with the intention of being acceptable and legitimate within the political or public sphere (Schmidt, 2008b; Schmidt, 2010b). Discourse is more than the ideas and includes the processes of interaction, and in particular the coordinative interaction that occurs between the policy actors who could be the drivers of change within governments, or the social activists deliberating and influencing across borders (Keck M, 1998). Institutional settings and context are also important, and the actors, if they know each other over time, are likely to develop their shared beliefs and ideas, which will influence their interests, including how they construct the discourse through the coordinative process of policy development itself (Nikola, 2011).

There are references by Schmidt (2010b) to ways that the DI framework has combined with the other NI approaches to observe particular processes of change. For example, in referencing her own earlier work and that of Blyth, Schmidt illustrates the ‘punctuation’ of the RI objective interests alongside the DI approach with a comparison of the 1930s period of the Great Depression and the financial crisis following the oil shocks of the 1970s. The term ‘Knightian risk’ is applied (Schmidt, 2010b, p8) to the certainty of the RI assumptions, that the calculation of subjective probability can be used in the explanation of the observation of a situation or phenomena at work, specifically in order to predict or at least explain the likely positions or interests. However, that same comparison of the two significant global economic crises of the 1930s and 1970s were, according to Schmidt (2010b) ‘critical junctures’ in terms of uncertainty and were followed by the reconstituting of interests, within a global economy that is not directly observable and in which the actors are not only unsure about how to achieve their interests, but also what they actually are. There follows a more detailed synthesis by Culpepper (Schmidt, 2010b, p9) that uses DI punctuated with RI on either side to consider the detail of the ideational processes through the changes in governance in France and Germany in the 1990s, highlighting a period of uncertainty between them that is better explained as ‘evolutionary’ rather than ‘revolutionary’. Further examples follow with HI in particular, because there is a greater overlap and ‘merging’ with SI and DI than there is with the other NI approaches. There are several scholars that argue HI can provide the structural framework for analysis and DI the framework to understand agency (Leiberman, 2005, p11 in Schmidt, 2010b, p12). This is a different consideration to the immediate explanation that things happen all the time outside of people’s control, or that their actions may be unconscious or without a clear purpose. It does, however, offer further potential to understand how the DI framework would be applied to the case study method by drawing out the distinctive perspectives that it offers to understand the dynamics of change. The coordinative sphere and the communicative sphere respectively include a wide range of communities, networks and individuals. The “arrows of discursive interaction” traverse from the ‘top down’ elites to the ‘bottom up’ of the deliberate policy influencers, but they may also remain at the level of civil society as ‘public conversations’ (Schmidt, 2008a, p5).

Schmidt reflects (Schmidt, 2010b, p15) that the scholarly application of the DI approach has been more significantly focused on the observation and analysis of ideas and that there is more that can be explored with regard to discourse. Some political scientists have, perhaps avoided a focus on discourse because of the potential association with post-structuralism and post-modernism, but this may miss the opportunity to use it generically to what is said, by whom, where and why. We “don’t for the most part engage in collective action or in collective (re)thinking of our actions without the articulation, discussion, deliberation and legitimisation of our ideas about our actions.” (Schmidt 2010b, p15). Discourse can be applied as a general and explanatory term for Habermas’ ‘communicative action’ and for the

‘discursive’ and ‘deliberative democracy’ that Dryzek developed, as well as the observations to be made within the coordinative and communicative spheres of policy construction and implementation. DI provides a framework, albeit with sometimes slightly ‘fuzzy’ boundaries, for the empirical analysis of the impacts of ideas and discourse on change. However, it does not account for the power of interests or within institutional structures themselves. This may be found missing in its application for this study and will be covered further in the analysis chapter that follows the case studies.

This section has described the application of a DI lens or analytical framework applied to the case study method of this study, and demonstrated that it needs to be situated within a clear research philosophy which is covered in the section that follows.

3.2 The research philosophy

The interpretive method is drawn from the social sciences qualitative approach that characterises the world through an understanding that there are multiple interpretations rather than a single, or absolute truth that can be determined. Yanow made the claim that (Yanow, 2003) constructivist and interpretive political analysis is a distinct research method because it examines the data from insider and outsider perspectives of observation, reading and interview, and then synthesises it to access and infer meaning. Given that this field is both developing and contested, and that it is also the frame for the inquiry applied to this study, it warrants further explanation from the theoretical perspective.

While research is broadly divided between the qualitative and quantitative approaches, they share the same common goal to understand the available evidence sufficiently to be able to infer meaning or to explain a theory (Creswell, 1998). The three key research paradigms are identified as positivism, interpretivism and realism, with the first two considered to be at each end of a spectrum and realism bridging and overlapping them in the middle. Positivism can be considered as more aligned to the physical sciences, drawing on realist ontological presuppositions and objectivist epistemological ones that make assertions on the basis of observable evidence. The distinction from the physical sciences is the development methodologically to test theories of causal relations to explain the social as well as the material aspects of the world. In this way the positivist researcher is able to draw on mixed methods that could include a case study as well as the deductive analysis of the behaviours, interactions, and events under investigation.

Realism acknowledges that the understanding of the field or particular subjects or phenomena being studied will be incomplete. This is because the ontological

position of the realist perspective is fundamentally objective and is combined with an assumption, or epistemology, that emanates from the personal or social interpretation of the world. Therefore realism draws from both the positivist approach of determining a position and complements this with the use of theoretical frameworks and methods that “determine the underlying mechanisms that influence people’s actions” (Stiles, 2003).

Within the field of interpretivism there are several different and contested perspectives that include paradigms such as ethnomethodology or symbolic interaction, as well as critical theory and constructivism, and have been referred to as the “paradox” of a naturalistic inquiry (Guba and Lincoln, 1994). The paradigm can be characterised as having an ontological position that is constructivist and an epistemology that is interpretive. What this means is the researcher is uncovering the subjective reality of the field of study, understanding that this will be different depending on the motivations and intentions of particular participants, as well as the meanings that are given in particular settings or contexts.

The argument is that knowledge is gained through the interpretation of the data available and so the approach assumes that the analyst cannot stand to one side of the issues being studied objectively. Rather, they will inevitably bring their own values, beliefs and experience to make their analysis. Within the public policy field, the analyst and indeed all of the actors in a policy situation will have an understanding of the material and actions that include the documents, legislation and the by-products and procedures of implementation. Each of these artefacts, independently and interdependently, will be understood as “not only instrumentally rational but also expressive – of meaning(s) including at times individual and collective identity”(Yanow, 2000). Hermeneutics takes this further in the consideration that human meaning can be projected into the full range of artefacts available to study. In this way, it is feasible to include architecture or the use of buildings for relevant participants or the field of study as well as symbols and symbolism to gain knowledge using the same analytical method.

The influences for interpretivism have derived from several scholarly fields including anthropology and literary theory, as well as contemporary political philosophy such as the ‘moral argumentation’ of Habermas (Collier and Esteban, 1999). The approach is less an argument in the context of understanding policymaking in practice, and more of a focus on the meanings given by the broad range of subject participants and the implications of this for using that knowledge.

Policy analysis has traditionally been applied to making sense of the choice of particular policy decisions or the particular use of instruments, such as legislation. However, this has been extended to include the evaluation of outcomes as well as the interpretation of policy. (Yanow, 2000) These roots can, according to Fischer, be understood as a concern about increasing the expertise for decision-making within

government, and “policy decisions combine sophisticated technical knowledge with intricate and often subtle social and political realities” (Fischer, 2003,p2). The ‘puzzle’ or ‘tension’ between what is expected by the analyst and what is actually observed, or between the different positions from the same data within a policy situation are unlikely to be changed by either facts or coercion.

The interpretive approach that is used in this study goes beyond the usual explanation of the field of inquiry to assess whether the DI theory is adequate in the potential observation of the dynamics of change itself. The intention in the application of the constructivist and interpretive approach is to explore beyond the diversity of language and ideas within the coordinative sphere, and to seek other perspectives that will be critical to the development of the discourse, and the enactment of the ideas. The approach of the constructivist and interpretive political analysis is to explore these contrasts in the meaning that is intended by the policymakers, through the authored texts and papers and the possibilities of different and even ‘incommensurable’ meanings from the constructed texts made by other policy relevant groups, and the further description and response to these constructed by other participants within the field of study. This inquiry is undertaken by taking the material apart, particularly the coordinative development of ideas and processes of discourse, and organising it into manageable parts so that it can be reconstructed again in a meaningful way to better understand the discourse in practice.

An interview with Dvora Yanow by Hernan Valenzuela (Valenzuela, 2012) explores some of the contestability as well as the development of the acceptability of an interpretivist approach to political science. For example, Yanow disputes the position that suggests there is no place for post-structuralism in the approach because of the lack of clarity about the subject being observed. “Whether we claim, explicitly to be using one school or another of discourse analysis or not, language is essential to the communication of meaning and to the contestations of it. [...] So I would say it is hardly clear” (Valenzuela, 2012, p121). Interpretive policy analysis emerged in political science field as a counterpoint to the rational positivist approaches such as cost-benefit analysis. On that basis it is more important to acknowledge the shared purpose of making sense of the data in order to infer meaning, than to contest the boundaries and differences in meaning given to discourse within the field of interpretive research.

3.3 Case study strategy

The questions for the research are both exploratory in terms of the potential to observe complexity and change, and explanatory in terms of revealing the range of actors and institutions. The questions are consistent with a case study approach and there is a logical case for the analysis of the material in this way that meets the conditions for adopting a case approach identified by Yin (2013). These conditions

include the contemporaneous events of institutional and policy change and the exploratory type of questions. The exploratory questions central to this study include consideration of the construction of discourse as well as the potential observability of the dynamics of change. This means that the traditional case study research approach is extended to include an investigation of the data to highlight what may be identified as the features or aspects of the processes of change. Whereas the usual approach of the case study method is to test or confirm a theory or to establish patterns, this research explores the traditional models of health policy construction and closely examines the interactions between the relevant actors in order to interrogate the dynamics and complexity.

There is an examination of the empirical documents that is assisted by the way that the case materials are organised within each chapter to identify the different groups of actors or institutions and their understanding. Additionally, the material is examined to question how those ideas are expressed, communicated and understood by others. Groups of actors and institutions relevant to the study are, as Spicker (2006) observes, interchangeable as the groups for whom the material or artefacts have meaning. This idea is further explored by Yanow (2000) with a number of examples of the different interpretation of frames, words and terms. In the context of this study, for example there is a distinction between the terms 'primary health policy' and 'primary health care policy' that has significance for the subset of 'health in all' policies. 'Primary health' is defined in the constitutional roots of the World Health Organisation as "the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", (WHO, 1948) whereas primary health 'care' refers to the entry point of care within the health system. The public health practitioners, health promotion practitioners and public health organisations will each make this distinction but the terms are regularly blurred by others, and contextually not assisted by the lack of a national definition for primary health policy in Australia.

There is a lack of rational explanation available for the dynamic of change and the construction of the discourse that is contributing to the changes in health policy. Previous research in policy and policy analysis has not provided the level of access that this study has. This enables a better understanding of the processes and interactions involved at the sub-national jurisdiction in a compound polity. This analysis of the local engagement and enactment of practice, including the conflicts and expression of issues, is only made possible because of the access to the material, and the professional position of the researcher as an integral participant in the process.

There is an important distinction to be made from the rational policy analysis approach (Davis G, Wanna J, et al 1993, p160-61) that assumes issues are stable and that problems can be identified as distinct with clear potential solutions to them. The rational model has limitations in its more prescriptive application than the

incremental¹⁴ policy analysis approach used in this research. This policy analysis is pursued through case material that utilises the interpretation, adjustment and compromise of day to day policymaking, as well as the interactions between the relevant actors as they execute their respective responsibilities for the longer term.

At an early stage in the research, consideration was given to the use of interviews as a component of the strategy, with the intention of including them. The research was established with a cross-sector executive leadership group that had the express commitment and support of the DHHS, and gained ethics approval to use the material from meetings and subsequent interviews with the individuals. Particular use has been made of the informal material from the author's notebooks that include impressions, observations and reactions to the discussions within the executive leadership group over the period of its meetings. The use of interviews would have the potential for high fidelity. However, as the study progressed the author found that interviews would provide less structure in terms of the core research questions, particularly in regard to the construction of discourse and the potential to observe complexity. Using the less structured, and potentially narrow field of observation available in the material from interviews would have added further to the volume but not the depth of content or rigour for the questions of inquiry.

3.4 The data collection

Having laid out the DI theoretical framework and the research philosophy that underpins it, the strategy has been described in the previous section, and this and the subsequent section will cover the treatment of the fieldwork and the material collected, sorted, reviewed and analysed.

The initial collection of data included those files and informal records that related to the overall management and development of the implementation of the Tasmania Health Plan. The records are mostly for the period of 2007, when the THP was launched, through to the State election in April 2010 and the closure of the initial implementation stage in May of that year. However, in order to observe the developmental activity that led to the inclusion of a Primary Health Services Plan (PHSP), further records and data were collected from the 18-month period prior to the launch of the THP in May 2007.

These records were then sorted into themes that informed the case study chapters, and the particular files and informal records that relate to each of these were

¹⁴ The main alternative to the rational model of analysis is 'incrementalism' attributed to Lindblom's "muddling through" Lindblom, 1959. in: *The Science of "Muddling Through"*. *Public Administration Review*, 19, 79-88, that recognised that in practice the ends and means of policy are often chosen simultaneously.

collected and then discarded once the final organisation of the material by case study was made. A description of the types of records for the overall coordination of the THP follows, followed by details of the relative number of records for each type. The material that was specific to each of the cases is organised in two further sections with the first of these combining the data collected for the first two case studies, and the final section relating specifically to the data collected for the third case study chapter relevant to the statewide chronic disease strategy. The types of records are organised as follows:

- Government publications
- formal records including notes or minutes of meetings
- informal records of meetings including hand written notes and emails
- plans, sub-plans and strategies, including drafts and preparative versions
- records of public consultations and community meetings
- Government political communication, including Hansard records and media releases and clippings.

There is also material relating to the author's observations including the:

- relative power of particular professions, groups of professions, institutions or components of the health system and ways in which this is manifest
- behaviours, acts and interactions between actors and institutions
- interaction between institutions such as the media, governments and different levels of government
- design and characteristics of the process of consultation in terms of location – where, with whom and with what amenity, and who doesn't go where, and why?

The record for this observational material is drawn partly from reflective analysis by the author, as well as the reference of hand written notes, informal records and emails that were collected during the period of the study.

3.4.1 Data collection relating to the overall coordination of the THP

3.4.1.1 Government publications

3.4.1.1.1 DHHS or Tasmania
State Government

| Type of publication | number |
|--|--------|
| Published Issues Papers, Strategies, Consultation Papers and Plans specific to the THP | 18 |
| THP Newsletters | 22 |
| THP Progress Reports | 8 |
| THP Community Forum Reports | 6 |
| THP Program and Project Fact Sheets (including drafts and updates) | 160 |
| THP newspaper advertisements (recruiting community members for consultations) | 5 |

3.4.1.1.2 Australian or
international
government
publications

| Type of publication | number |
|--|--------|
| Published Plans, Issues Papers, Strategies, Proposals, Reviews and Consultation Papers relevant in general to THP e.g. Richardson Review 2004 | 35 |
| Published Plans, Issues Papers, Strategies, Proposals, Reviews and Consultation Papers relevant in general to THP and specific to individual proposals within the THP e.g. The Whitehorse Report | 104 |
| Australian Department of Health and Ageing (as it was formerly to 2014) publications including national policy statements and plans, proposals, evaluations, election commitments e.g. The Way Forward | 28 |

3.4.1.2 Formal records including notes or minutes of meetings

| Description of formal record | number |
|---|--------|
| THP Coordination Group ¹⁵ agendas, minutes of meetings and related correspondence including Terms of Reference and Governance papers (total 30 meetings) | 66 |
| Briefing papers, reports, budgets and business cases prepared for THP Coordination Group meetings: | |
| 2007 (5 meetings) | 19 |
| 2008 (10 meetings + 2 cancelled) | 62 |
| 2009 (10 meetings, 4 of which were rescheduled + 1 cancelled) | 47 |
| 2010 (4 meetings + final project closure meeting) | 18 |
| Gantt chart 'traffic light' internal progress reports | 36 |

¹⁵ The Coordination Group was the 'steering committee' responsible for guiding the implementation of the THP

| | |
|--|-----|
| Internal DHHS briefing papers and Ministerial or Cabinet briefing papers | 43 |
| Media releases | 5 |
| Project and program outlines | 184 |
| Consultant reports | 8 |

3.4.1.3 Informal records of meetings including hand written notes and emails

| Description | number |
|---|--------|
| Ring-bound A4 notebooks with approximately 80 pages in each, maintained by the author in the form of a chronological account of formal and informal meetings, telephone conversations and face to face meetings with individuals, observations of activity and interaction, questions and conflicts, covering the period November 2007 to March 2010. | 8 |
| Archived emails (approximate total) | 15,000 |

3.4.1.4 Plans, sub-plans and strategies, including drafts and preparative versions

| Type of publication | number |
|--|--------|
| THP Primary Health Services and Clinical Health Services Implementation Plans, sub-plans, evaluation and consultation plans, implementation governance plans (total of 14 core documents) and drafts | 58 |
| Project and program plans for main initiatives (total 148) including briefing notes, budget proposals, draft outlines | 200 |

3.4.1.5 Records of public consultations and community meetings

| Description | number |
|---|--------|
| THP community stakeholder relationship records including questionnaires, evaluation, workshop presentations and handouts, photos, correspondence, recruitment files | 11 |
| Site visits and consultation reports | 7 |
| Preparative and associated work to site visits and consultations including | |
| • Written responses to consultations, preparative to the THP (2006) | 146 |
| • Local Government profiles (29 in 2006, and then updated each subsequent year) | 116 |
| • Letters, meeting requests, catering, room bookings for a total of 42 site consultation visits, and 8 community consultation meetings between 2006 and 2009 | 270 |
| • Presentations, photographs and feedback notes | |

3.4.1.6 Government political communication, including Hansard records and media releases and clippings

| Description | Number |
|---|--------|
| Hansard records | 18 |
| Media clippings, including press releases | 16 |

3.4.2 Data collection relating to the first two case studies: a primary health services plan and a tiered services model

3.4.2.1 *Government publications*

3.4.2.1.1 DHHS or Tasmania State Government

| Type of publication | number |
|---|--------|
| Published Issues Papers, Strategies, Consultation Papers and Plans Specific to the PHSP including the consumer engagement strategy, integrated care centres and tiered services delivery models | 11 |
| PHS Newsletters (Newsletter 3 April 2008 brought the THP into a coordinated implementation model) | 2 |
| PHS Program and Project Fact Sheets | 34 |

3.4.2.1.2 Australian or international government publications

| Type of publication | number |
|--|--------|
| Published Plans, Issues Papers, Strategies, Proposals, Reviews and Consultation Papers relevant in general to PHSP e.g. NSW, Vic, SA reviews of primary and community health, Victoria Primary Health Partnerships | 9 |
| Published Plans, Issues Papers, Strategies, Proposals, Reviews and Consultation Papers relevant to individual proposals within the PHSP e.g. Bayside Consumer Participation Model, Whitehorse Health Promotion Plan | 6 |
| Australian Department of Health and Ageing (as it was formerly to 2014) publications including national policy statements and plans, proposals, evaluations, election commitments e.g. National Primary Health 2020 papers, GP Super Clinics | 8 |
| Plans, strategies and reports relevant to the PHSP published by other countries e.g. UK, USA, Canada, New Zealand, other European countries, or other OECD countries, the OECD or WHO e.g. various primary health reports | 8 |

3.4.2.2 Formal records including notes or minutes of meetings

| Description of formal record | number |
|---|--------|
| PHSP, and specific project and program Steering and Advisory Group meeting agendas and minutes of meetings, including briefing papers for PHSP meetings (there are documentation gaps because many of these meetings were organised within primary health services) | 25 |
| Agendas and papers for ICC meetings | 43 |
| <ul style="list-style-type: none"> Papers and agendas for related national meetings e.g. GP Super Clinics | 18 |
| <ul style="list-style-type: none"> Project documentation for Agreement with Australian Government for funding for GP Superclinic Clarence (including letters, emails and drafts of the contract) | 39 |
| <ul style="list-style-type: none"> Project documentation for Agreement with Australian Government for funding for Launceston Integrated Care Centre (ICC) (including letters, emails and drafts of the contract – there are documentation gaps because some of this was directly managed by the LGH/ Northern Area Health Service) | 18 |
| Internal relevant DHHS briefing papers and Ministerial or Cabinet briefing papers | |
| PHS stakeholder and community relationship records including questionnaires, evaluation, workshop presentations and handouts, photos, correspondence, recruitment files | 20 |
| | 268 |
| Consultant reports | |
| Project and program outlines (some of these are duplicates of 3.4.1.2) | 7 |
| | 135 |

3.4.2.3 Informal records of meetings including hand written notes and emails

| Description | number |
|-------------|--------|
| See 3.4.1.3 | |
| Notebooks | 8 |
| Emails | 15,000 |

3.4.3 Data collection relating to the third case study: connecting care

3.4.3.1 Government publications

3.4.3.1.1 DHHS or Tasmania State Government

| Type of publication | number |
|---|--------|
| Published Issues Papers, Background Paper, Strategies, Consultation Papers and Plans specific to the THP statewide coordinated chronic disease strategy | 4 |

| | |
|---|----|
| Published Plans, Issues Papers, Strategies, Proposals, Reviews and Consultation Papers relevant in general to Chronic Disease Strategy e.g. Chronic Disease Framework 2005 | 47 |
| Workshop agendas, invitations, flyers, drafts of presentations, written notes, photos | 46 |
| Published Plans, Issues Papers, Strategies, Proposals, Reviews and Consultation Papers relevant to individual proposals within the Chronic Diseases plan e.g. <i>Health Promotion Background paper, Self-Management Framework, Your Care Your Say</i> | 5 |
| Virtual Network Newsletters, CD Network newsletters | 9 |
| Project Fact Sheets | 5 |

3.4.3.1.2 Australian or international government publications

| Type of publication | number |
|---|--------|
| Australian Department of Health and Ageing (as it was formerly to 2014) publications including national policy statements and plans, proposals, evaluations, election commitments e.g. Coordinated Care Trials, The Way Forward, National Chronic Disease Strategy, National Service Improvement Frameworks (NSIFS) | 9 |
| Plans, strategies and reports relevant to Chronic Diseases planning published by other jurisdictions including ACT Chronic Disease Strategy 2008-11, Queensland Health Chronic Diseases plan 2005-2015, NT Preventable Chronic Disease Strategy | 5 |
| Plans, strategies and reports relevant to Chronic Diseases planning published by other countries including UK, USA, Canada, New Zealand, other European countries, or other OECD countries, the OECD or WHO – NCD response, Long Term Care strategies | 3 |

3.4.3.2 Formal records including notes or minutes of meetings

| Description of formal record | number |
|---|--------|
| Chronic Disease Strategy Steering and Working Group meeting agendas and minutes of meetings | 18 |
| Briefing papers for Chronic Disease Strategy relevant meetings | 57 |
| Internal relevant DHHS briefing papers and Ministerial or Cabinet briefing papers | 14 |
| Consultant reports | 2 |
| Consultation reports | 11 |
| | 192 |

| | |
|--|--|
| Stakeholder relationship records including virtual and formal network member recruitment, feedback, questionnaires, evaluation, workshop presentations and handouts, photos, correspondence, recruitment files | |
|--|--|

3.4.3.3 Informal records of meetings including hand written notes and emails

| Description | number |
|------------------------------------|-------------|
| See 3.4.1.3 Notebooks Emails | 8 15,000 |

3.4.3.4 Plans, sub-plans and strategies, including drafts and preparative versions

| Type of publication | number |
|--|--------|
| Chronic Disease Strategy proposals, Implementation Plans, sub-plans, excerpts and drafts including main strategy development, briefing notes, draft outlines | 78 |

3.4.3.5 Records of public consultations and community meetings

| Description | number |
|----------------------|--------|
| Consultation reports | 11 |

3.5 The actors and institutions

The empirical material that was selected in order to analyse health policy change, focussed on primary health and a “comprehensive” primary health approach. The context of the primary and community health policy and service environment is that there is a diversity and volume of multiple actors and institutions involved. In Chapter 1 (sections 1.2 and 1.3) there was an exploration of some of the factors that contribute to the particular complexity within this sub-set of health policy. This identified that complexity includes societal issues of ideology such as the extent to which citizens have individual agency and power to make lifestyle and behavioural choice. This is reflected in the generally conservative and constrained political action that has not allocated or redistributed resources to this area of health policy, perhaps because of the need for longer term and cross sector strategies.

There were multiple actors and institutions in Tasmania that were involved in the THP and they are identified in each of the case study chapters that follow. The deliberations between the actors and institutions internally within DHHS was a particular emphasis within the case study chapters and therefore the following table introduces these key internal actors and their relationship to the overall leadership of the Department (DHHS) as well as to the THP.

| Institution/actor group | Relationship to THP | Relevance to each of the case study chapters |
|---|---|---|
| <i>DHHS Executive</i> | Leadership group for the central bureaucracy, responsible for the THP, and led by the Secretary. | Feature in Chapter 4,5 and 6 |
| <i>THP leadership</i> | Internal leadership group established to oversee the THP, includes members of the DHHS Executive and other relevant senior staff | All of the former governance structures were combined into the THP Leadership group in January 2008, and feature particularly in Chapter 5 and 6. (includes the author) |
| <i>PHSP Leadership</i> | Internal leadership group established to oversee the development of the PHSP, includes members of the ComET, led by the Deputy Secretary Community Health | The initial developmental work for the PHSP from 2005-8, after which it was combined into the THP leadership group. Features in Chapters 4, 5,6. (includes the author) |
| <i>Community Executive (ComET)</i> | Internal to DHHS, the Community, Population and Rural Health (CPRH) Services Executive group, led by the Deputy Secretary Community Health | The initial developmental work for the PHSP from 2005-8, when it was restructured. Features in Chapter 4. (includes the author) |
| <i>Acute Health Service Executive (ACE)</i> | Internal to DHHS, the Acute Health Services Executive group, led by the Deputy Secretary Acute Health | Restructured in 2008. Features in Chapter 4. |
| <i>Mental Health Services and correctional health</i> | Internal to DHHS and member of ComET | Features in Chapter 4 |
| <i>Alcohol and Drug Services</i> | Internal to DHHS and member of ComET | Features in Chapter 4 |
| <i>Primary Health Services Executive</i> | Internal to DHHS and member of ComET. Key actor and institutional involvement in the PHSP development and implementation. | Features in Chapter 4, 5 and 6 |
| <i>Population Health Services</i> | Internal to DHHS and member of ComET. Key actor and institutional involvement in the PHSP development and implementation | Features in Chapters 4 and 6 |
| <i>Rural in-patient services, including MPCs and community health centres</i> | Internal to DHHS and managed by Primary Health Services Executive until restructure in 2008 when they became part of the Area Health Services structure. Key institutions for PHSP implementation | Feature in Chapters 4,5 and 6 |
| <i>Hospital, ambulance and acute out-patient services</i> | Internal to DHHS and managed by Acute Health Executive until restructure to Area Based Health Services in 2008. | Feature in Chapter 4 |

Figure 7 Key internal DHHS actors and institutions relevant to the THP

There were other actors and institutions that are featured in the case study Chapters that are not identified in Figure 7. These are mainly organisations and actors that are external to the DHHS and are identified within each of the cases as relevant. In particular Figures 15,16 and 17 in Chapter 5 identify the actor groups and institutions directly impacted or involved with the implementation of the proposed tiered service delivery model for Primary Health Services under the PHSP.

3.6 The method for organisation and analysis into the cases

This primary material has been separated and sorted retrospectively, noting that there are complexities in the volume and range of institutional actors and groups involved for whom the author has artefacts in the form of informal notes and observations, rather than interviews. The policy analytic question entails change at the macro- political level of national and international health policy discourse, whilst the material study is at the sub-national jurisdictional level of Tasmania. The research has included, therefore, an interpretation of the discourse and the documents that inform the primary health policy of the Tasmania Health Plan, as well as the internal machinations within the coordinative sphere. This is an important component of the method if the research is going to be able to reach beyond local interpretation to potentially make general statements about health policy change.

In order to ensure that there is credibility, transferability, dependability, and conformability to the analysis (Guba & Lincoln, 1994) the material was systematically sorted into different groupings that ultimately became the case chapters that follow. In terms of validity in particular, multiple sources of data need consideration in order to make causal inference. The principles to apply to the relative importance or relevance of particular material are derived, in part at least, from the hermeneutic orientation of the interpretive approach by Klein and Myers 1999 who indicate that it is not a mechanical process. The researcher has to decide what to present, and in what form, depending on the audience and the story to be told.

Once the cases were identified and the material was organised into the perspectives that illuminate the questions, there was a further layering of sampling to enhance the possibilities of comparative analysis. In the grounded theory tradition of reviewing interviews, this is referred to as discriminate sampling by “choosing persons, sites and documents that saturate categories and complete the study” (Locke, 2001). The point of saturation is not an absolute, but rather a judgement by the author that the balance of evidence is sufficient to provide inference in response to the particular element of inquiry. Despite what cannot be a detailed technical data analysis, the cases can derive a plausible cogency by developing the analysis of the material through different perspectives, themes and participants and their institutions within the field of study. Yin (2013) describes the “thick descriptions” that are possible and

that the case study approach is appropriate for projects that extend over a long period of time.

3.7 Participant-researcher and the limitations of the research

The participant-researcher provides an observational analysis that highlights the different views from an insider and outsider perspective, or when the artefacts or processes of their application are hidden from view (Jorgensen, 1989, p4). The author in this study is a senior executive officer in DHHS, Tasmania, and as such was intimately involved during the period of the study as a participant in the process, an observer for the purpose of this study and as a leader in the implementation of the THP. In order to observe the construction of discourse and ideas within the DI theoretical framework of the coordinative sphere, it is critical to get beneath the surface of the public documents and examine the material that sits behind it which would otherwise be hidden from view. This is a highly relevant feature of the study, and the level of access is unlikely to have been possible without it. Through participant observation “..it is possible to describe what goes on, who or what is involved, when and where things happen, how they occur and why – at least from the standpoint of the participants – things happen as they do in particular situations” (Jorgensen, 1989, p3). Jorgensen describes six minimal conditions that are most appropriate to be informed through participant observation and each of these is satisfied in this study as follows:

1. The research problem concerns meaning and interaction viewed from the insider perspective of the coordinative sphere.
2. The investigative phenomenon – in this case the construction of discourse, and the volume and range of actors and institutions – is observable within an everyday situation or setting.
3. The researcher is able to gain significant access that is directly relevant to the research.
4. The phenomenon of investigation is sufficiently limited in size and location to be studied as a case.
5. The research questions are appropriate for case study
6. The research problems can be assessed through direct observation and collection of qualitative data.

While all analysis aims to arrive at true and objective findings, the social sciences deal with the subjective and so it is important to consider the personal bias of the participant-researcher. There are many scholarly works that have discussed the processes and procedures that are used by both physical and social sciences to

achieve truth (Jorgensen, 1989)¹⁶. The process is that of disciplined description that the author has applied to establish a hermeneutic or interpretive understanding of the material. There are no universal patterns that can be applied or stated about the period in time and the situation and context for the study. The research questions, founded from the theoretical constructs of DI and its scholarly roots, provide the framework within which the material has been reviewed, sorted and interpreted.

The data in this study is contextual and includes the words, acts and the participant-researcher observations and notes, as well as the copies of documents. There has been no reinterpretation of the documents collected by the author and selected for the case studies. The research strategy includes the structuring of the cases and the selection of excerpts from documents in order to reveal the actual words used by others, the development of particular ideas and discourse, and the place and context of activity. The author has made diary observations as a participant that have not been reinterpreted, and subsequent reflections that inform the research process and that are, by their nature, an interpretation. This, as Yanow refers to (Yanow, 2000) is more appropriately data 'access' than 'collection' and is therefore particularly valuable in terms of the insights and access available to the author of this study.

3.8 The limitations of the method

The methodology chapter would not be complete without consideration of the limitations of the approach. There may be limitations with DI as the analytical and theoretical framework for the study.

While DI has been applied in the field the research, so far, it has not been applied to the participant-researcher analysis of relatively small scale policy construction within the coordinative sphere of a sub-national jurisdiction. Many of the studies that have applied DI to date are researching large scale policy changes in either time or place. (Schmidt, 2010b; Miorelli, 2013; Schmidt, 2008a; Schmidt, 2010c) This may present limitations with the theory itself when it is used to question the material. In particular, it may be found to be insubstantial or distinctive enough in granularity, especially being built on and from the other NI theories.

Given that DI does not have a developed methodology there are not many critiques that have been published. There are, inevitably, documented limitations to constructivism, the interpretivist approach and institutionalism and these are revisited in the closing section of the Analysis in Chapter 7. There is a critique of interpretivism

¹⁶ Jorgenson, in the chapter on methodology within the book *Participant Observation* 1989, refers to Kuhn's work (Kuhn, T 1970. *The structure of scientific revolutions*, Chicago, University of Chicago Press) as seminal in acknowledging the pursuit of accuracy, but in seeking to understand the philosophy of science he also stated that truth is not an absolute and rejected value freedom even as an ideal.

and the pitfalls of qualitative research in practice (Kahlke, 2014). There are limitations of the case study interpretivist method, with Rhodes, for example (Bevir & Rhodes, 2005) stating that it provides the “account of actions and practices that are interpretations of interpretations”. The same paper does, however, argue a case for the ‘situated’ agency of the actor and observer that explains some of the rationale and value of the approach to political science. Finally, the limitations of being a participant-researcher, are considered with particular reference to the limitations of interpretivism and the utility of DI as a lens to observe the dynamics of change.

The study is undertaken from the perspective of the author and there will be less observable alternate perspectives from other institutions, particularly from outside of government. This may impact on the assertions that can be made more broadly from the observation and analysis, particularly when they are in the communicative or public sphere. There may be limitations with the location in time and place to providing enough material to answer the research questions. Is the boundary of the sub-national jurisdiction of Tasmania an adequate field of study for these questions, and is the timing of the period the material was gathered relevant and contemporary to the changes in health policy? The purposive sampling of the fieldwork is, paradoxically, appropriate for the research questions which require a searching approach to uncover and expose perspective and evidence (Guba & Lincoln, 1994, p40). The case study method is common to many contemporary studies in political science and provides the opportunity for intensive investigation of a particular time and place (Gerring, 2004). While no logical or rational inference can be drawn from the observation of a single case phenomenon, the case material consists of multiple observations of the configuration, interactions and dynamics across multiple institutions and actor networks and settings. My focus on the interrogation of the material relating to a relatively short period of time within Tasmania is well suited to the bigger question of the consideration of fundamental health policy change. This is because of the exploratory nature of understanding the dynamics of change itself, and the author’s lived professional experience of the multiple differentiated subgroups of interests that emerge, compete and converge at the intersections between institutional and network boundaries.

Ethics approval was gained for the involvement of interviews with senior staff in DHHS and the material pertaining to their personal commentary relevant to the implementation of the Tasmania Health Plan.

3.9 Summary of the research design methodology

| Options and variants for consideration | Decision choice |
|--|--|
| Ontological positions and epistemological assumptions | constructivist interpretive |
| Analytical framework | DI |
| Research strategy | Multiple case studies |
| Features of method | Participant-researcher with significant access |
| Field of study – place and time | Sub-national state: Tasmania, Australia Development and active implementation of THP 2006-2010 |
| Sub-fields selected | Primary Health Services Plan (PHSP) |
| Selected cases | 1. Establishing the case for a PHSP 2. A tiered service delivery model 3. Developing a Chronic Disease Strategy |
| Structure in outline | Institutional arrangements Engagement strategies Assessment of impact or intended outcome |
| Inquiry | Political analysis of health policy change |
| Theoretical framework as applied to Case 1: Establishing the case for a PHSP | Qtn 1 and 3: moving the discourse from the coordinative to the communicative sphere |
| Theoretical framework as applied to Case 2: A tiered service delivery model | Qtn 2 and 3: The agents of change – who they are and how they convey the ideas |
| Theoretical framework as applied to Case 3: Developing a chronic disease strategy | Qtn 1 and 3: How and where the ideas emerge and the observation of the interactive processes of a developing discourse |

Figure 8 Summary of research method

CHAPTER 4

4 Establishing the case for a Primary Health Services Plan

This first case study is particularly focussed on agenda setting, and in terms of the DI literature it highlights the boundary between the internal 'coordinative' discourses within government agencies to the political 'communicative sphere' of politics and the general public. The healthcare system in Tasmania (governance, design and delivery) is similar to that of other jurisdictions in Australia, with a normative discourse that is dominated by hospital and institutional care and change that has been relatively small-scale over time (Richardson, 2004). A study in London, for example, of a 'modernisation initiative' across several institutions over a period of 9 years (Macfarlane F, et al 2013) drew on the three social forces or 'pillars' that were identified by Scott to demonstrate the challenges of fundamental and sustained change. The researchers observed the agency of institutional "entrepreneurs" (Kingdon, 2003) as they influenced the establishment of new structures and governance, new care relationships and professional practices. That study found that the greatest evidence of what could be described as sustained change occurred through the cultural-cognitive 'assumptions' of best practice to establish change. Similar implications are observed in this case study where the key actors promote the discourse that gets traction over time.

This chapter researches the context setting for the early discussions about the importance of primary health issues in Tasmania from September 2005 until December 2007. The authority to proceed with a primary health plan was given in 2006 and there followed a series of consultative meetings around the State in 2006 and a collation of the responses received from organisations, health professionals and community members. The empirical data reveals the agency of staff, particularly the small group of key internal actors that subsequently lead the implementation of the PHSP. The analysis follows the methods and approaches to get onto the agenda over the course of the first year, and their dispositions and actions to develop the discourse in order to gain broader legitimacy for the policy problems that the Government would release as a plan in 2007. The seminal writers on the themes of discourse, ideas and change are Colin Hay (Hay, 2001), John L. Campbell (Campbell and Pederson, 2004), Mark Blyth (Blyth, 1997). They have influenced DI and its development by Vivien Schmidt (Schmidt, 2002). While there were externally aligned policy processes at work identifying the importance of developing stronger primary health approaches, it is the endogenous change that is observable in this chapter. DI has, arguably, more ability to provide the analytical purchase on questions of complex institutional evolution, through the adaptation and innovation applied by the actors within context. The intention of the case is to observe the interplay and development of the ideas and concepts within the coordinative sphere and between

institutions, including the context within which the interplay of ideas and institutions can be observed. The case is able to highlight how structures of the agenda setting is achieved in Tasmania. This has resonance with Sabatier's advocacy coalitions (Sabatier & Jenkins-Smith, 1993) and the relationships, shared values and patterns of interacting that developed as part of it (hence on the normative legitimacy of the senior and less senior actors).

The Primary Health Services Plan was not included in the original development of a State Health Plan for Tasmania which instead focused on hospital efficiencies and a clinical services review. However, there were growing concerns about the sustainability of the small inpatient facilities that had been a major component of the community model of care since the 1980s. The combined impacts of an ageing workforce, the increased emphasis on clinical quality and safety, and the population drift away from the rural communities was causing a slow but predictable decline in services. In line with contemporary health policy thinking, such as the review of primary health by UNSW (McDonald, 2004) and regional implications, in particular, in the New South Wales reports,¹⁷ (Owen, 2008; Eagar, 2008) senior leadership staff within DHHS could see benefit in adopting a primary health focus with a broader social view of health that would alleviate the pressures on acute care services.

This first case study chapter pays particular attention to the construction of the policy discourse, the boundaries between the coordinative and communicative sphere, and the processes of getting onto the policy agenda. The focus of the material that is drawn out for this chapter is about the various methods that established the case to include a dedicated focus on primary health within the State health plan (the THP), including the internal institutional meeting papers, ministerial briefings, and reports. The observation of how, and in what ways, the discourse was shaped and influenced as it moved from the coordinative to the communicative sphere (Schmidt, 2010d; Schmidt, 2011b) is of particular relevance to this chapter, and is significant for the first of the three core research questions: How are policy discourses constructed in the coordinative sphere?

The case material in each of the three chapters is analysed through the same structural outline that includes the institutional arrangements, the engagement strategies and the assessment of impact (if any). The first of these in this chapter is referred to as conceptualising the issues and considers the bridging and linking between the various organisations and formal and informal networks involved. This is followed by section two, on legitimising the ideas in parliament, and section three, on communicating internally through actors and institutions. Each of these sections of the case study explore and review the material with reference to the ways that proposals and messages were conveyed between organisations and networks,

¹⁷ These reports review primary health models internationally and nationally, and propose the need for a greater policy investment in primary and community health care.

including to the State Government. The final section of the chapter covers the impact of change and reviews the established program logic and other evaluation tools that were applied.

4.1 Conceptualising the issues

Tasmania has a relatively stable population of approximately 500,000 people, disaggregated in many small rural settlements, and predicted to grow slowly over the next decades, levelling out by 2040. The proportion of younger people in Tasmania is predicted to decline, while the proportion of people aged 65 years and over is projected to grow from around 16 per cent of the population in 2011 to 27.2 per cent by 2056 (Australian Bureau of Statistics [ABS], 2011). Tasmania has acute hospitals in each of its three regions and a number of rural facilities that range from nursing centres and community health centres to multi-purpose facilities that combine subacute and aged care. Many general practitioners combine their practices in State-run rural facilities.

Some of the recent socioeconomic trends in Tasmania are referred to in the State of Public Health Report:

“Social indicators present a mixed picture of progress, with some improvements in education and incomes, but also higher unemployment noted since 2006. In December 2012, Tasmania had the highest rate of unemployment (7.3 per cent) of all jurisdictions. Additionally, the estimated long term unemployment rate for Tasmania (1.5 per cent) was the highest in the country, as was the estimated under-employment rate (9.3 per cent). Tasmania has the highest proportion of people living below the poverty line, as a result of very low median incomes and a high reliance on government income support payments.” (DHHS,2013,p24).

The Report’s executive summary puts these issues in context for the delivery of health care in Tasmania with the following comment (DHHS, 2013, p3):

“A major tension arises from the fact that significant growth in health care system funding will divert resources away from other social goods in order to expand a care system that – for a variety of reasons – has difficulty defining its boundaries. From a public health perspective, this limited view of health as ‘health care’ is slowing more effective progress in those things that predominantly determine overall population health and wellbeing outcomes, and that are mostly outside the direct influence of the health care system.”

The impacts of social and economic disadvantage to health outcomes are further expanded in Chapter 1.

A strong impetus for the THP came from the review of the Tasmanian Hospital System by Professor Jeff Richardson in 2004 (Richardson, 2004). This found that the health system was unsustainable in Tasmania, and made particular reference to the need to consolidate the acute hospital services in the north west of the state in a way that would more closely align with the population base and its health care needs. It was not the first report that had made such a recommendation, but the timing is important in that it was published 18 months before a State Government election.

The Richardson Report also acknowledged that hospital reform had to be linked to building a strong primary and community health care sector, and provided several specific statements that were valuable to the case for a primary health focus. The following are some excerpts:

An efficient, effective hospital system relies on support from a strong primary, community and aged care service system. (Richardson, 2004,p33)

The hospital system will only be efficient if there is coordination between both the different levels of hospital care and between hospital, primary health care, and other ambulatory services. This requires access to appropriate alternative forms of care. (Richardson, 2004, p59)

Early discharge and the optimal use of expensive hospital facilities depend on the quality of the primary health care system. (Richardson, 2004,p20)

The discussion about the need for clinical services redesign established a policy window (Kingdon, 2003) for the Community Population and Rural Health Services Division (CPRH) within DHHS to raise the need for reform of primary and community services with the DHHS Executive Committee, the central bureaucracy leadership group for DHHS. Concurrent concerns about sustainability had been raised through to the then Deputy Secretary for CPRH. These senior staff who were (at that time) members of the leadership group of the CPRH could, in DI terms, be seen as the 'agents for change'. They were the key actors evident in what Schmidt describes as the coordinative sphere of discourse, where the negotiation about the legitimacy of the change that was needed had been occurring for some years. The Executive Committee for CPRH were called ComET (Community Executive Team).

The aims and objectives of ComET were described as:

To establish a consistent policy and service delivery approach across community-based health and community care services. To strengthen the linkages across service areas in response to increasing complexity of client needs. (Complex needs include people living with comorbidities, disability clients, people with poor access to, and need for, health and community care,

people living with chronic mental health and poor physical health, older people, and people living alone etc.) To strengthen the system's capacity to imbed a preventative approach into service delivery and to address increasing incidence of chronic disease (using a 'common risk factor' approach). To establish strong links across the community, including with local government and community sector organisations, etc.(DHHS, 2005c)

There are several examples of the developmental process of the discourse occurring systematically and persistently through the leadership of the CPRH Deputy Secretary from early 2005, until approval was given in August 2006 to establish a PHSP.

An overview of CPRH was provided to the Secretary of DHHS in September 2005 (DHHS, 2005c) outlining the need and the rationale for change:

Over the last three years there has been a systematic reform process implemented across the community-based services aimed at improving access for clients, using current resources more effectively and achieving statewide consistency in service models. This is an incremental approach with many of these having been done quietly, with staff participation and without creating a high degree of community or industrial awareness. While much remains to be done, and the easier elements achieved already, there is a solid base to work from and a good understanding of overarching directions within each service that change needs to progress. These directions are well described in the principles developed as a whole-of-agency guide and in summary can be described as:

- local responsiveness within a statewide consistent approach
- clear role delineation that reflects the relationship between primary and specialist services
- imbedding preventative approaches into direct care services
- improving consumer engagement
- improving accessibility by simplifying entry to the system, assessment and referral processes
- seeking more effective uses of resources by altering service models, professional's roles etc. to gain better value to money and/or capacity to expand services.

A further rationale for the CPRH and its executive committee – ComET - was to:

[...] strengthen the voice of community care as a counterbalance to the dominance of hospital care within the agency and to provide strong leadership at a time when the Agency's senior management [DHHS Executive] were required to concentrate on acute care issues.

And further notes by the Deputy Secretary referring back to that time (DHHS, 2006b) read:

Community expectations influence Government responses to health service provision but are often ill-informed and unrealistic. Little effort has been made to better inform Tasmanian communities about resource allocation choices. In an environment when there is no debate about what is affordable or safe health care, responses to such situations as threatened closures by private operators of regional health services, whether it be Mersey Hospital or a small radiography clinic in [a rural location] inevitably result in reactions to invest whatever it takes to keep the service open. As workforce shortages and quality and safety issues impact on the sustainability of rural and regional services, community education and exploration of alternative models of service delivery will become even more necessary.

The following extract from a Framework Report about Community Participation at rural Primary Health sites in Tasmania (DHHS, 2005a) is indicative of the case for change being made by the senior policymakers in CPRH and its organisations and programs:

The purpose of this framework is to provide both policy direction and practical resources for effective community participation at sites managed under the ARCH [Aged Rural and Community Health] program [in CPRH]. The framework recognises the value of community participation in setting strategic directions for community health services and is underpinned by the expectation that there will be some form of community participation at all sites. (DHHS, 2005a, p5)

The benefits of participation at the local level were articulated as follows: (DHHS, 2005a, p8)

- improved health for community members
- improved program results and strengthened support for regulatory and policy decisions
- increased public confidence in the health care system
- a more informed public that understands and participates in the full range of health issues

- stronger, healthier communities
- an organisation that is citizen-focused and responsive to changing needs
- increased capacity of health services to build better relationships between services and the community and to foster the development of holistic and integrated approaches to health care
- establishment of partnerships and the development of solutions, including the mobilisation of resources and energy, and ensuring the ownership and sustainability of programmes
- development of appropriate services or policies through a consultation process which clearly identifies the community's needs
- the health service understands the full range of impacts of a proposed initiative and can, therefore, take appropriate action.

The challenges and concerns about how to tackle these systemic problems had been internally considered and contested within the leadership group for CPRH. There had been a relative stability in the leadership structure that included all of the primary, community, population, mental health and rural services in a single Division. See Figure 9 for Organisational Chart 2005. (DHHS, 2005d).

Organisational Structure

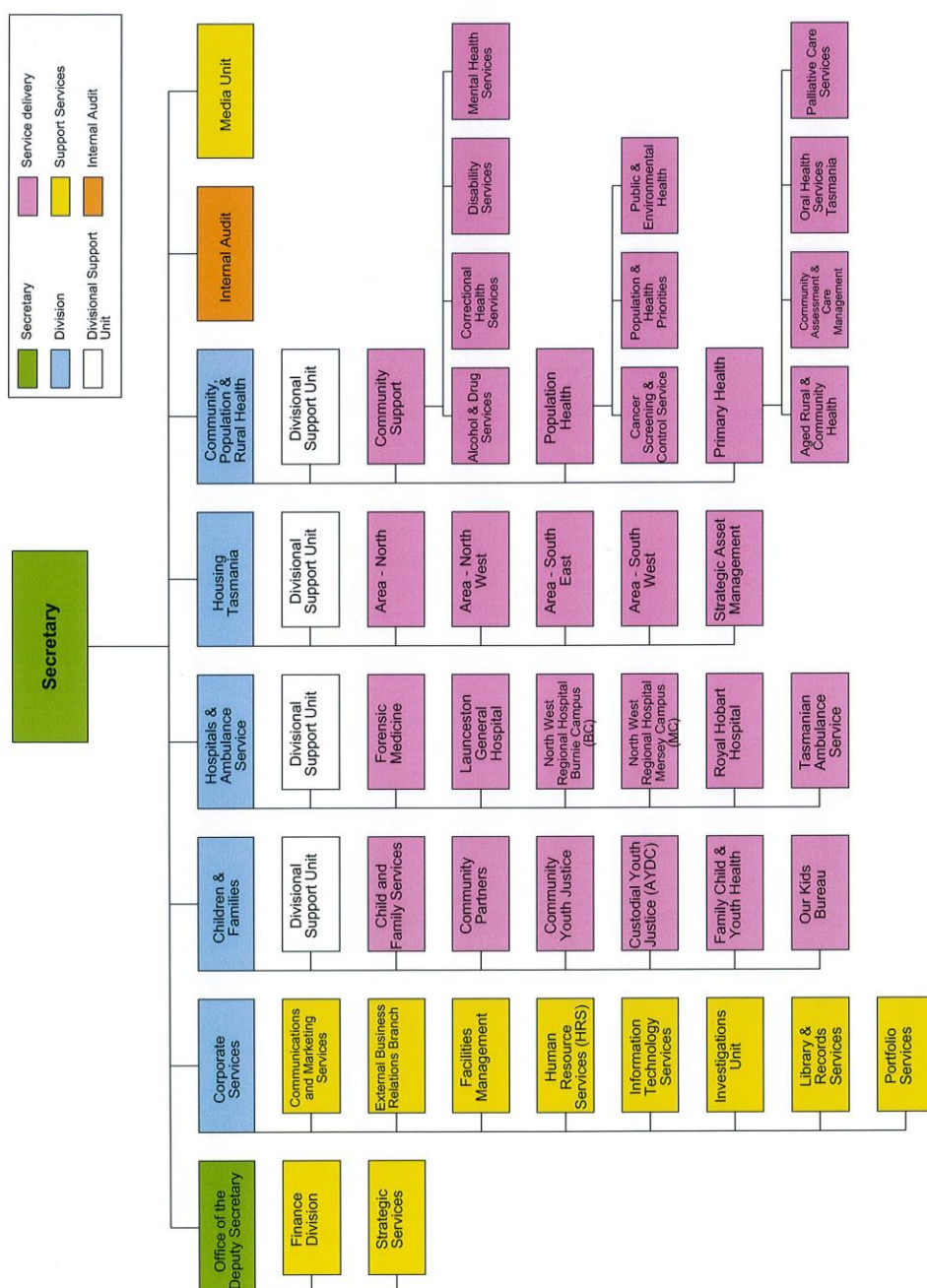


Figure 9 DHHS Organisation Chart 2005 (DHHS, 2005d)

A Divisional Support Unit (DSU) was part of the structural support to the Deputy Secretary and provided advice to the leadership of DHHS.

A briefing from the Deputy Secretary CPRH and the discourse that the senior leadership were shaping for change, describes the challenges of “capability to meet demand” as follows:

Many reviews and reports have identified that as well as facing higher levels of demand than in other states, community care services in Tasmania do not have the base level of service delivery that might be expected for a population this size. For example, Palliative Care has half the number of inpatient beds compared with national standards. Mental Health Services support about 50 per cent of the expected population with mental illness. This results in a high level of unmet need that inhibits the agency’s success in meeting demand. In addition, resources are not always wisely used and there are a range of changed service delivery practices that could improve service sustainability and client access. Incremental progress is occurring but more needs to be done. (DHHS, 2005c)

4.1.1 Getting onto the Minister’s agenda

The further representation of this discourse being established by senior leadership in the DHHS executive is evident in the following extracts of briefings for the incoming Government and a new Minister for Health and Human Services in April 2006.

The first of these was prepared by the Primary Health Services Executive and provided by the CPRH through the Secretary:

Tasmania moved in the 1990s to rationalise some rural health services and many district hospitals were converted to residential aged care facilities with a small number of subacute beds and to expand their role to manage the community care needs of their communities. Some hospital inpatient care facilities continue to be provided on a stand-alone basis where there are viable private nursing homes to undertake the aged care role. Service locations are historical and in the case of inpatient facilities are more likely to represent Tasmanian cultural expectations than nationally accepted benchmarks. Rural hospital/health sites provide a wide range of services and are regarded as highly important (even ‘icon’ status) by their surrounding rural communities. By national standards however some inpatient sites would tend to be regarded as too small and unviable.

Key issues for the Alcohol and Drug Services, another program within CRPH were identified as:

The viability of the Alcohol and Drug Service and its capacity to meet demand has been the subject of public debate ... the Alcohol and Drug Service is a

small specialised service and while Commonwealth funds have extended the non-government alcohol and drug sector, very little increase in resources has occurred in the government service.

And finally the briefing on Palliative Care Services, that was another program area within CPRH:

Government endorsed the directions set out in the review report in June 2004 and identified priority areas for immediate implementation. This was reiterated publicly by the Minister for Health and Human Services at the time of the Palliative Care week in May 2005.

In the current financial year Palliative Care has experienced a 13 per cent increase in clients accessing services. This is contributing to staff burnout and the provision of palliative care medical specialist services has again reached a crisis point in Southern Tasmania.

Expenditure had been steadily rising because the depleted rural workforce, where staff were retiring faster than they could be replaced, and was causing an increase in the use of locums to cover nursing rosters. At the same time revenues were declining, in part from the decline in the number of war veterans whose care costs were generously subsidised by the Australian Government Department of Veterans Affairs (DVA). This combination of factors had sparked an analysis of the financial and workforce sustainability of the inpatient rural health services in Tasmania (DHHS, 2005c). Some of the information in this unpublished report was referenced and updated for the health plan, but it was never published because it was too stark in its revelations about the slow and inevitable decline of the rural in-patient facilities.

The Minister's office was provided with further details about the options for rural inpatient facilities by the Deputy Secretary CPRH on 29 March 2006:

The first option is to maintain current service delivery structure and invest additional resources in maintaining viability – even if only in the short term. Note that the risk of serious quality and safety adverse incidents due to reliance on locum staff and poor continuity of care will still continue.

Alternatively, the preferred option is to realign services to ensure greater sustainability. This would include the closure of the least viable higher risk sites, recognising that there may be a subsequent risk of loss of GPs and adverse community reaction. However the critical workforce shortages may force this result. (DHHS, 2006a)

Within the context of spiralling costs of health care generally, Tasmania had identified that there were particularly high opportunity costs associated with the

provision of inpatient services in some of its smallest rural facilities compared to larger urban hospitals. The costs and the opportunities to utilise that funding differently within those same communities was shared during all of the first three phases of the introduction of the THP – there was an initial strategy discussion paper, the issues paper, and then Primary Health Services Plan.

Rural hospital facilities were shown to consume nearly half of the overall primary health care budget while community health centres had five per cent and home care ten per cent (DHHS, 2006e, p12). At the same time there was a demonstrable downward trend in the occupancy rates and acuity of patients in rural inpatient facilities between 1998 and 2005. This was attributed to the combination of more specialised care being provided at the larger regional hospitals, and the increasing mobility of the rural population, many of whom were travelling to regional centres for work and school. There was also a change in aged care policy during the 1990s that aimed to enable people to maintain their independence at home for longer, and this contributed to the reduced utilisation of rural hospital beds. These changes in health care trends that were observable in Tasmania were commonly happening elsewhere (Eagar, 2008). However, these facts were to be perceived differently from the perspective of the rural community, the policymakers and leadership group, and differently again by each of the staff groups in the primary and community care sectors, compared to the health care providers in the larger regional hospitals. These differences, and most importantly the perceived loss of services to a largely rural population, presented a challenge to Government policy for all agencies in terms of communicating change and maintaining quality local services.

A formal case for a 'Primary Health Collaboration Project' (DHHS, 2006d) was made by the Deputy Secretary CPRH to the Minister for Health and Human Services, and cleared by the Secretary for DHHS on 17 July 2006, describing it as having the following intended outcomes and scope:

Outcomes sought: The project seeks to achieve greater sustainability in primary health service delivery and more streamlined delivery of services between primary health providers in Tasmania. In the longer term, this will improve health outcomes by overcoming barriers to the provision of multidisciplinary coordinated care across the different sectors in the health system.

Scope: The project will examine issues and recommend strategies (both short term and longer term) regarding primary health service delivery models, workforce recruitment and retention, and communication with local communities relating to primary health services in Tasmania, including general practice, community health services and country hospitals.

It will also seek to strengthen the partnerships already being developed between General Practice and a range of DHHS services such as Mental Health, Alcohol and Drug Services, the acute hospitals and Population Health.

In response to the question of how the project would be resourced, the Deputy Secretary stated "... several options are being considered and will be subject to further discussion. It is recognised that project resources are required to implement this substantial project."

The commitment to a Health Plan for Tasmania was made at the start of a new Labor Government in April 2006 with a new leadership of the health portfolio by the Hon. Minister Lara Giddings. This was initially focused on a clinical services review of the care provided through the larger regional hospitals and the ambulance and patient transport services. The Government approval to progress inclusion of a primary health services plan did not occur until the end of September that same year.

There was continuing representation made to Minister Giddings by ComET, the leadership group in the Division of CPRH, through the Secretary. During the first months of her term of office in the new Government, it was proposed through formal briefing papers that the Minister should have serious concern about the vulnerability of the rural and community health sector. There was a determination by the senior staff group that something needed to be done, and the issues were re-presented several times and in different formats.

4.1.2 Legitimising the ideas in parliament

The internal policy narrative by the senior executive actors within ComET and its sub-organisations, particularly in Primary and Population Health Services, presented the need to act. There was an argument to include primary and community health reform with the clinical services review as a necessity and was presented in several different ways in order to gauge the political appetite. One of the more persuasive was its presentation as a quality and safety issue with the clinical risks of the declining skilled rural workforce that was being supplemented by locums in order to keep facilities open. The other argument that was mounted was the broader policy consideration of the need to develop better linkages between services, and establish a more contemporary approach with greater emphasis on outreach and community services rather than inpatient care. It is hard to know whether Minister Giddings was convinced about the positive opportunities or that, rather, she was concerned that the consequences of doing nothing would be too great a political risk. The convincing argument for the need for change was the clinical risks to rural patients and the lack of sustainability concerns with locum staff. These were the concerns taken to Cabinet in order to make the case for including primary health reform in the plan.

The Tasmanian State Government House of Assembly is elected from five multi-member districts, the largest of which is Lyons which covers most of the rural area of the State. The former Minister for Health, the Hon. David Llewellyn and the Hon. Michael Polley were both popular and powerful in the Labor party in Tasmania, and ranked first and second of the total of five elected members for the rural electorate of Lyons. The ABC profiled the Lyons electorate in 2006 as:

[...] a bits and pieces electorate made up of the 40,604 sq km (60 per cent of the State) ... stretching from the east to the west coast ... covering 13 local government areas ... it is important for the parties to provide regional balance to their ticket. David Llewellyn and Michael Polley are the biggest vote pullers for rural Tasmania. (Australian Broadcasting Commission [ABC], 2006).

The Primary Health Services Plan (PHSP) development could have been unlikely to have achieved approval on its own merit, but the importance of the rural electorate of Lyons in Tasmania meant that the timely presentation of the problems of sustainability gained collegial support between the party members in rural seats before Cabinet gave approval to proceed in 2006.

By April 2007 (DHHS, 2007h) 44 per cent of the Primary Health Services nursing workforce employed by DHHS was aged 51 years or over and 77 per cent of the total workforce were between 40 and 60 years of age. The average age of Tasmanian GPs in 2006 was 49.7 years, with approximately one third of the workforce over the age of fifty five (Tasmanian General Practice Division, 2006).

Few rural facilities were large enough to offer clinical placements for nurses in training and the new workforce was tending to choose the larger urban hospitals in the state for employment. Concerns about clinical safety in these facilities were driven by a combination of factors that included the increased use of locum nurses, an ageing workforce with limited exposure to diversity in clinical practice, infrequent professional development and an erosion of contemporary skills. There was also a decline in the full time rural general practice workforce resulting in contracts to supply doctors who were often internationally trained and, together with the locum nurses, had limited local knowledge and possibly less commitment to these facilities and communities.

Approval for the development of the PHSP followed the approval to proceed with the Clinical Services Plan and, not surprisingly, had a much smaller budget. On 27 September 2006, Minister Giddings made the announcement publically through a press release stating:

Health and Human Services Minister Lara Giddings today said that Tasmanians would benefit from the development of a statewide plan for primary health services.

‘Primary health is a critical part of the health care system and getting it right is essential if we are to improve individual health and relieve pressure on acute care services,’ Ms Giddings said.

‘While traditionally primary health providers have focused on the care of the sick, there is strong support at a national level to extend the emphasis to the development of health.

‘This includes a focus on population as well as individual health, health promotion and education, and community involvement, improving the continuity of care and integrating prevention.’ (Department of Premier and Cabinet Tasmania [DPAC], 2006)

Political support, however, especially for an ambitious reform in a richly contested area of policy such as health, was fragile especially with rural communities. These communities were facing the challenges of a slowly changing identity with declining needs for agricultural and forestry labour and a general population drift to the bigger towns and cities. Hearing that the cost of providing inpatient services locally was not sustainable financially would not have given much comfort, and the messages about a community and primary health focus may have been hard to understand as a positive improvement. There were a number of possible options for criticism by the Opposition from the outset. Hansard records an early point-scoring angle by the Hon. Brett Whitely, then Shadow Minister for Health, on 13 June 2007 (Tasmania Parliament, 2007), just weeks after the launch of the THP, in which he said: “[...] is this not a crusade of the city versus country, a bureaucratically forced social engineering project?”

Unsustainability is the story of slow decline, but while the clinical risk implicit in the small rural facilities was of sufficient concern to be part of the rationale for change, it was not possible to present this publicly. There was a need for the message that would generate the ideational turn for the mainstream. A sense of urgency was required to inspire the reform and one that was used for dramatic effect was that of the boundary between the coordinative and the communicative spheres, and that health would consume the whole of the State Government budget by 2021 unless something significantly changed.

Speaking at the launch of release of Tasmania’s Health Plan, 24 May 2007, the Hon Lara Giddings, Minister for Health and Human Services said:

It is time to grasp the chance for change. Already the clock is ticking. A 'perfect storm' is brewing. Demographic, technological, chronic disease, workforce and inflationary pressures are pushing Tasmania's health system to the brink.

Having established a parliamentary commitment to proceed with a PHSP, it was important to bring the broader Tasmanian community to the same view.

The PHSP (DHHS, 2007h) brought together all of the discussions that had been conducted formally through consultation, and included the opportunity for response from members of the public. The intention of the PHSP was to articulate an acceptable proposal for service redesign that would gain the agreement and commitment from the public that what was proposed would better meet the changing needs of the Tasmanian community. In frank but perhaps less critical language that some of the preparatory documents stated, the Primary Health Services Plan recognised that while Tasmania has a relatively stable population, it was getting older and there were some locations in the State that were declining in population.

In particular, it referred to the decline in population in some parts of the State, such as the West Coast, while other areas such as the East Coast were attracting new people, indicating the need for changes in services and infrastructure to reflect these population movements.

The emphasis was on extending and expanding the role of rural health facilities to be more flexible by providing more day services for visiting allied health, respite care, and greater access to home based services including palliative and post-acute hospital care.

Early in the Plan it was stated for example:

Where services cannot be delivered safely, effectively and at an acceptable cost from within local communities, access to services should be facilitated through service coordination, the provision of outreach services from an external base, the use of technology, transport assistance and other appropriate community support. (DHHS, 2007h,p5)

And later:

All rural health centres will be maintained. There will be an increased focus on the prevention and management of chronic disease, on services aimed at maintaining people in their own homes, on the local delivery of components of specialised primary health care, and the development of closer linkages with general practice and the broader health system. There will be some changes

in bed usage where safety and sustainability cannot be assured. (DHHS, 2007h, p61)

The public were being persuaded through direct and indirect assertion that the current and small inpatient rural health facilities would need to be phased out over time.

Tasmania's PHSP put forward a constructive case for redesigning the existing primary and community health services to better meet the needs of the changing population and, in particular, to increase the focus on prevention and community-based care with the intention to relieve the pressure on hospitals. This arguably positive narrative that equates to Stone's discussion of communicating ideas (Stone, 2002 p137-162), was being constructed as a means of providing appropriate levels of care closer to where people live. This argument was more to do with the coordinative discourse that developed the policy legitimacy internally to the Department, and its various executive groups, and within the relevant service areas of aged, community, primary and mental health services. The argument was particularly targeted at the rural and dispersed population centres, and the purpose included the reduction of inpatient facilities that served a small number of people and enabled more emphasis on primary and community health promotion that would have a greater reach and build capacity toward better outcomes over time.

An extract from a Budget Estimate briefing for the Tasmanian State Budget in 2007 stated:

The Department will support this approach (to reducing chronic disease) by:

- Increasing the number of Health Promotion Officers to work with Primary Health Coordinators in communities throughout the whole of Tasmania.
- Providing increased effort in cessation of tobacco smoking specifically targeting those most at risk, such as young women, Aboriginal people or those with mental illness.
- Identifying population groups most at risk of chronic disease, with an initial focus on diabetes, and providing appropriate risk modification and early intervention support programs.
- Increasing effort in mental health promotion, including suicide prevention programs.
- Building the skills and capacity of the health workforce in health promotion and self-management through the expansion and evaluation of training programs for different work groups and working with the University of Tasmania, other education providers and the DHHS Population Health.

- Disseminating nutrition resources for school canteens, aged care and residential settings and the development and distribution of improved self-help tools for people at risk or with chronic conditions.

The plan introduced a set of principles to guide the more detailed consideration of planning for each of the projects and initiatives that would be applied to each separate context.

| | |
|--|--|
| Services will be accessible as close as possible to where people live as long as they can be provided: | |
| 1. | Safely, effectively and at an acceptable cost |
| 2. | Appropriate to the community's needs |
| 3. | Client- and family-focused |
| 4. | Integrated with the other elements of the health service system |
| 5. | Designed for sustainability |
| 6. | Focused on health promotion, illness prevention and early intervention |
| 7. | Delivered in a culturally appropriate manner. |

Figure 10 Principles for the Primary Health Services Plan in Tasmania's Health Plan

These principles were further explained as follows: Where services could not be delivered safely, effectively and at an acceptable cost from within local communities, access to services would be facilitated through service coordination, the provision of outreach services from an external base, the use of technology, transport assistance and other appropriate community support.

Accessibility referred to those primary and community services that could be provided locally from within communities. This would likely be at the local Government level. Any service would be regarded as feasible to be provided if there was enough client throughput and sufficient activity to support a professional workforce that could provide a safe quality service and cover for reasonable hours of availability to the community it served.

Appropriateness to the community needs would need to be determined by a combination of factors including the population and demographic profile, as well as the potential delineation of the service with respect to the professional support between regional and rural centres.

Acceptable cost would be based on an understanding that public resources for health care should be applied in a responsible budgetary environment, recognising that resources are not unlimited and that sometimes choices have to be made to trade one service or part of a service for another. This would be based on evidence of effectiveness and within the parameters of the other principles applied to planning and development of local services (DHHS, 2006g).

These principles were developed from the discussions during the consultation, and the issue of 'acceptable cost' was raised several times, including in written submissions. This indicated that cost is one of the more challenging concepts for the community to understand, and that there was a need for additional explanation.

"Government and the community aim to achieve the best possible value for public expenditure, so that the greatest community benefit can be achieved. Some services, because of their remoteness or special local factors, inevitably will cost more than equivalent services delivered in other locations. Responsible planning, however, requires that an assessment is made of whether significant additional costs incurred to provide services in particular settings are justified by a corresponding health benefit. A decision about whether a service cost is acceptable, therefore, involves an assessment of the financial cost of providing the service, the benefit individuals and the community derive from the service, whether alternative services are available, and the cost to individuals and the community of accessing those alternative services." (DHHS, 2006g)

Sustainability was another central concept in the Tasmania Health Plan and the PHSP in particular. Services that were intended to be designed and developed for sustainability would take account of the need for effectiveness in having, for example, sufficient client or patient throughput and volume. This would be in order to maintain the quality and competence of the health care professionals providing them. The staff required to support a particular service would need to be sufficient to withstand temporary shortages and vacancies without incurring the additional cost burden of supplying locum staff. Temporary staff employed either as locum or fixed term contracts have been found to compromise the continuity of local care knowledge.

Other aspects of sustainability include the need for predictability of funding over time, access to clinical and non-clinical support services, and transparency in the costs and in the decision-making to meet the context of competing demand for limited resources. The consequences of having services that do not adhere to these sustainability principles for planning can result in the compromise of safety and quality because of the need to modify other services at short notice, or inadequate timeframes to cover service gaps. There may be delays in recruitment, inadequate staff training, and excessive costs to achieve temporary solutions, or poor

communication and integration of care with other services at the regional or area level.

The underlying principles and intent were based on sound and rational consideration and considerable consultation and discussion with frontline staff, community sector organisations, local government, local communities and elected members. The THP as it was laid out, including the PHSP, provided a strong case for all that it proposed.

Getting the agenda onto the table was a significant achievement and the main focus for this Chapter. The next, and still early, stage of the planning process was to establish an implementation plan. There were coalitions of interests and there was evidence of cooperation and interest in the development of the PHSP. There was partnership and the coordination of ideas that were incorporated into the plan. What was less evident, however, was the depth of relationship between actor interests and institutions. The level of consensus for the reform was unknown and there was an (as yet) untested question of whether there was enough environmental readiness for implementation when it started later in 2007.

Minister Giddings was seen to have been courageous (or reckless depending on the perspective) in taking up the challenge of implementing reform on the scale of the THP. While the political challenge was made explicit and was supported in Cabinet, there were conflicts of value and some indicators of a lack of trust between different professional groups, sectors, levels of government and between citizens and various institutions that was identifiable early in the process, in the responses to the initial consultation.

The proposed change from rural inpatient services to community-based day care was perceived as a significant threat in the small rural communities that were directly impacted. These communities were already in general decline with population drift and a cumulative loss of services that went with it. One community, for example, had a population of 130 people, and the overall population of the Local Government municipality numbered 2,294 in 2005 and was projected to decline by a further seven per cent by 2018. It was difficult for staff at the facilities in these communities to separate their loyalties locally within their communities, and indeed one of the strongest protagonists to maintain the service status quo was a retired former member of staff. Despite the opportunities for new models of care, it was the changes proposed to these rural facilities that drove the biggest wedge between people locally. The relationships between local community based services and senior leadership is often strained, particularly between rural and city groups, and there was a break down in the opportunities for implementation that was predictable from the outset.

Abstract goals that have a “motherhood” benefit that everyone can get behind are successful in the early stage of bringing the agenda to the table, but interests tend to

prevail in the longer term. Most organisations that can be identified by location, type (such as community health centre), or by their sub-groups of professions or interests, will favour the maintenance of status quo wherever possible. While there was an interest, a willingness, and indeed a consensus to join with the themes of the work ahead, there may have been a superficiality that was not even conscious or deliberate but had the causal consequence of even greater fragmentation as the early stages of implementation were applied. Within rural communities the organisations and professional interests extended to local individuals. This was reflected in an increase in the number of submissions from individual citizens at the second stage of the initial consultation. It was individuals who were beginning to voice their concerns about the loss of services in their communities, most notably in the communities that were flagged to change in the early stages of implementation in the central region and north western areas of Tasmania.

4.2 Communicating internally through actors and institutions

Notes from the Deputy Secretary for CPRH (DHHS, 2006c), provide the first steps in articulating a PHSP for the key senior leadership staff to make a start on the research and development of documents for public comment:

“Why do we need it?

- Primary care is a critical part of the health system
- Research shows that well-functioning primary care system improves health outcomes and reduces health system costs
- Tasmania’s system needs considerable improvement and reform
- This has been done piecemeal without an accepted Government position on the future direction of primary care services in Tasmania.

The process as it is mapped out is not a simple one: the task is not simple if we are to achieve a plan that provides us with a 10-year time vision but also provides guidance on how services are to be delivered on the ground. Important to get it right, considering that it will be used as a rationale for significant reform/change process and where Government is being asked to make decisions about critical service issues.

While the plan identifies state-wide strategic priorities and the actions needed to implement these, it has to do more than that:

- It needs to provide an objective framework through which information can be evaluated and arguments for change mounted. This will be subject to considerable scrutiny.

- It will need to commission research into demand patterns in primary care and apply these to future service delivery planning.
- It will need to define what the clinical requirements are for safe service delivery in rural hospitals and then apply this at the local level. This will take into account relationships with the major hospitals. This could become the basis of formal clinical networks. It also can be the basis for decisions about the long term sustainability of some 24/7 services.
- It will develop a model of service delivery that is based on local primary care networks, across government, private and non-government, linked in to local government and with formalised links back to the major hospitals. Hub and spoke models will be the basis for this thinking.
- We will aim for a primary care system that is responsive to local needs, but one which we can afford and one that both supports the prevention and population health agenda as well as the work of secondary and tertiary services.” (DHHS, 2006c)

The preparative work toward a PHSP began following the Minister’s announcement on 27 September 2006 and the consultation is summarised as follows:

| Date | Key action/document | Key stakeholder meetings | Face to face consultation |
|---------------|--|--|--|
| October 2006 | Primary health staff informed by memo | DoHA UTAS Divisions of General Practice ABS RACGP GP Workforce Tasmania | |
| November 2006 | | Local Government Association of Tasmania, Australian Medical Association and Australian Nurses Federation Tas Branches, and Health and Community Services Unions, and Cradle Coast Authority | Summary: North – 6 consultations North West – 2 Consultations South – 6 consultations Details: Triabunna (S), Swansea(S) St Helens (N), St Marys (N) Deloraine (N), Westbury (N) Kings Meadows (N), Ravenswood Devonport (NW),Ulverstone (NW) Clarence, Rosny (S), Sorell (S) Brighton (S) Clarendon Vale (S) |
| December 2006 | Primary Health Strategy for Tasmania – launched by Minister 5 December Development of Local Government Profiles | Three regional workshops to consult primary health staff, GPs and GP organisations, local government, DoHA, community sector organisations and UTAS. | Summary: North – 5 consultations North West – 5 Consultations South – 7 consultations Details: Campbelltown (N), Scottsdale (N) George Town (N),Beaconsfield (N) Flinders Island (N) Hobart (S), Kingston (S) Ouse (S) Bruny Island (S),New Norfolk (S) Huonville (S),Oatlands (S) Queenstown (NW),Smithton (NW) Burnie (NW), Wynyard (NW) King Island (NW) Total attendance: 318 |
| January 2007 | Local Government Profiles completed and distributed to all 29 council Mayors and GMs inviting comment | | Local Government meetings in Break O'Day (N), Dorset (N) and West Tamar (N) |
| February 2007 | | Multi-site video meeting re GP specific interests Tas COSS DoHA | |
| March 2007 | Primary Health Issues Paper- launched by Minister 27 March | Senior DHHS staff together with consultants in rural health from WA Centre for Rural and Remote Medicine Meeting with rural doctors at conference in Shearwater, North West (31.3.2007) | Summary: North – 1 consultations North West – 6 consultations South – 5 consultations |
| April 2007 | | | Summary: North – 14 consultations North West – 5 consultations South – 9 consultations Overall total attendance: 734 |

Figure 11 Primary Health Services Plan Consultation

There were 72 responses written to the Strategy Paper, and 74 responses written to the Primary Health Issues Paper, making 146 in total. An internal project management structure was established on October 2006 with initially one member of staff working directly to the then Deputy Secretary CPRH, and the support of the relatively recently established Primary Health Executive Group (PHEX) (see Appendix 1: Structure). This new Primary Health Services structure was intended to support the Plan at every level with a strengthened management and regional structure, and a new role of Primary Health Care Network Coordinators across the State. The first steps, in addition to gathering data and initiating the literature reviews, included the launch on 5 December 2006 of a discussion paper, “A Primary Health Strategy for Tasmania” (DHHS, 2006f) by Minister Giddings. This outlined the challenges facing the current primary, community and aged care sector and was used to stimulate discussions over the summer period of November 2006 to February 2007.

There were 72 submissions received in response to the discussion paper, and notes were taken at consultations and workshops with staff from the sector. The Primary Health Services Issues Paper (DHHS, 2006e) followed quickly after in early 2007 to build on the consultation and propose the model that would be established in the forthcoming plan, and received a further 74 responses.

| Responses received from | Total number 74 (100%) | Comments |
|--------------------------------|---------------------------|--|
| Department staff | 40% | Half were from allied health staff, and the rest mostly nurses |
| Consumers | 17% | |
| Professional bodies, Unions | 10% | This includes the Divisions of GP organisations ¹⁸ |
| Community sector organisations | 9% | Including TasCOSS |
| Local Government | 7% | |
| Interstate | 6% | Primary health institutions |
| Individual GPs | 6% | |
| Politicians | 3% | |
| Education | 1% | Faculty of Health, UTAS |
| Private Business | 1% | |
| Overall total: | 100% (74) | |

Figure 12 Summary of the written responses to the Primary Health Services Plan Issues Paper

¹⁸ In 2007 there were five GP Organisations in Tasmania, each operated as separate, though related, entities.

The framing of the challenges in the Primary Health Strategy document was not replicated into the final version of the PHSP because the language was seen as too negative to make any proposed PHSP seem possible. For example, "...how will/or would primary health care be provided with the resources to change their existing services?" (DHHS, 2006f, p4) was changed in the PHSP to be:

However, the Tasmanian primary health care system also shares less positive characteristics in common with other systems nationally and internationally, namely a tendency to respond to issues one at a time, rather than taking a whole of system approach. Some of these characteristics of the primary health system in Tasmania are:

- fragmentation and lack co-ordination, both within the primary health care sector itself, and with the acute hospital, mental health and social support sectors
- historically based, and overly complex, funding arrangements which consolidate the bulk of resources into clinical/hospital settings
- inconsistent planning and funding mechanisms
- lack of strong community and consumer input
- lack of capacity to systematically plan for, and adapt to, major demographic changes, including population mobility, population ageing and specific areas of need. (DHHS, 2006g)¹⁹

The Primary Health Services Issues Paper (DHHS, 2006e) laid out the data regarding demographics, illness, workforce and poor and costly bed occupancy at many rural facilities, and was structured round a series of questions that encouraged the sector, and the public more broadly, to respond. It was proposed that a new tiered and statewide service model be established for primary health services that would improve the match between service distribution and population need and set clear expectations for the general public and communities about what services would be available where. The proposal was based on maintaining the rural and community-based services as a key locality-based resource and developing the linkages locally as well as improving access and referral to specialist of regionally provided services.

The framework for services was based on the distribution of workforce and services that would:

¹⁹ This was part of the submission by the Campbelltown Multi-Purpose Services Advisory Committee received in an email in response to the Primary Health Issues Paper, December 2006.

[...] reflect the complexity of service provision, the extent that other services need to be involved, or other support provided for safe and reliable practice and the services/ geographical coverage. (DHHS, 2006e, p23)

What started as strong alliance between unions, professional groups, rural organisations and their committees, began to break down as the implications of real change hit home. Both the problems and the potential solutions to them were understood differently within the primary care sector and there was a significant underestimation of the investment that would be required to facilitate the changes proposed.

What was articulated as a vision of service improvement and modernisation in response to the crisis of the epidemic of chronic disease, was broadly understood and acceptable, especially when it was focused on patient-centred care and enabling people to take more control over their health and participate in decision-making. However, the problems of escalating cost are more complex and were likely to be contestable with different concepts regarding what could be described as priority or necessary expenditure depending on the professional group, sector, service or location.

4.3 The impact of change

The intention of the PHSP was to develop the capacity and capability of the primary health care sector in Tasmania such that the features noted in the first definitions at Alma-Ata (WHO, 1978) would be in evidence. However, the extent to which there were clearly articulated in terms of specific initiatives and interventions was limited. There were challenges in setting out an implementation plan with a limited budget and an ambitious intention of building a sustainable and integrated sector.

The PHSP was focused on establishing a sustainable model of care that identified the person-centred and inter-professional potential relating to local linkages between general practice, primary and community health. There was an emphasis on health promotion, prevention and early intervention by increasing the skills and capabilities of existing community health services staff and their relationships with their clients and communities.

In February and March 2008, senior DHHS managerial staff conducted another consultation tour of the state that included meetings and visits to 32 Primary Health Services sites across Tasmania and a total of 37 community consultation sessions with local staff and community members.

At each of those community forums, there were questions about the justification of the need to change services in rural locations, and the methods of consultation,

particularly in the Central Highlands. However, the most recurrent themes in the structured discussions at each of three forums were that there should be greater emphasis on innovation, reform and on establishing more preventive and primary health approaches (DHHS, 2008e). References to the importance of new models of working and the chance to make improvements were made in each of the forums, and in response to different presentations as well as the discussion. There was active discussion about a social and more holistic model of health and involving people and communities in developing their own skills and increased individual responsibility for health. Notions of health promotion and early intervention were also incorporated into discussions at each of the forums.

In the Tasmania Health Plan Newsletter issue 12, March 2009, the DHHS Secretary was quoted talking about the importance of engagement:

Department of Health and Human Services Secretary said his agency was determined to make community engagement a reality. "When I talked to people at Ouse about how to resolve their issues they told me they wanted three things: to be heard, to be trusted and to be respected," Mr Roberts said. "We have to be brave enough to go and listen to what people are really saying," he said. "Community engagement is a mindset but we also have to find the mechanisms to hear the community's voices; that's probably a five-year journey (DHHS, 2009d).

There were likely to be as many variations on the levels of understanding for why a primary health focus was important as there were actors. Among community members there were active and informed people who were knowledgeable and engaged about policy and scholarly thinking in other parts of Australia and internationally, just as there were many long term health professional staff that saw the potential changes as threatening to their practice and position.

The approach to evaluation was to use a 'program logic' framework. This method captures the context for what is being planned and the constraints and opportunities that are anticipated. The program logic framework also provides the opportunity to quantify the investment input and to list the intended results. The method is particularly valuable in articulating the intended outcomes or longer term results. The program logic for the PHSP (DHHS, 2007f) was drafted as follows:

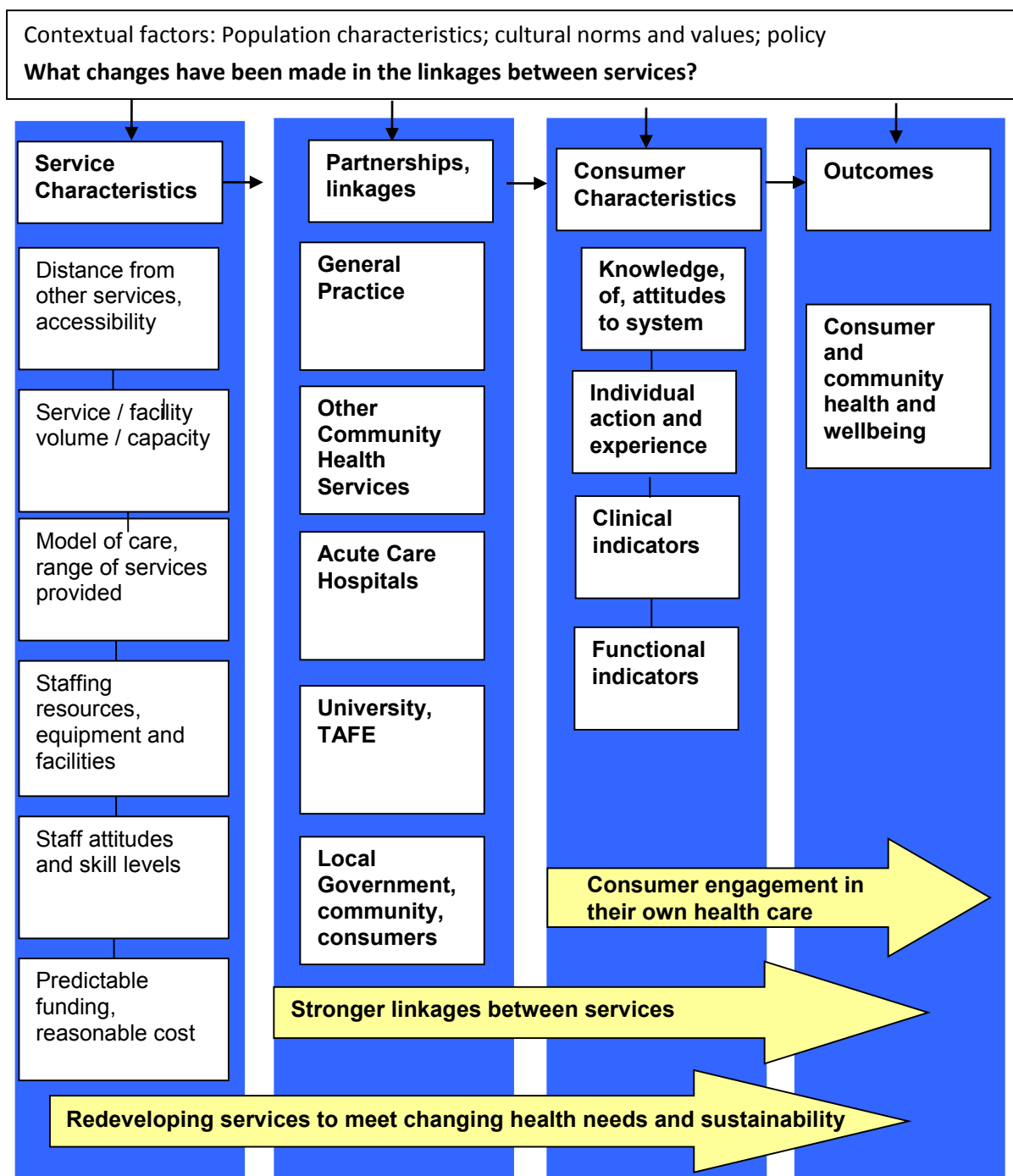


Figure 13 Program Logic Evaluation Model: Primary Health Services Plan

The PHSP outlined the methods that were to be applied for the implementation and evaluation process: (DHHS, 2007h, p130) it would be guided by the Tasmanian Government Project Management Guidelines, and its success would depend on the active participation and involvement of local health professionals, community and rural health facility staff, local government and community members. The proposed structure for Primary Health Services within CPRH, replaced the Aged Rural and

Community Health program that had previously included most of the same services, together with palliative care and community allied health. The new organisational structure for Primary Health Services was designed to include primary health 'coordinators' in each of seven regions of the State. The primary health coordinators were identified as a critical support role to the implementation of local primary health partnerships and the proposed new models of care, particularly with respect to the engagement of local government and community members. Specific funding was to be provided for formal evaluation of the outcomes of demonstration projects. Several sites and services were identified, and the intention was to include process evaluation and project analysis across all of the implementation streams. The following questions were drafted toward the intended evaluation, including:

- Have project outputs been delivered as outlined in the PHSP Implementation Plan?
- Has the delivery facilitated achieving the objectives set out in the PHSP?
- Have the objectives facilitated achieving the desired outcome?
- What changes have been made in the service characteristics?
- What changes have been made in the linkages between services?
- What changes have been made in the way health service consumers experience these services?

The evaluation was designed with the intention to ask outcome questions that would interrogate whether changes had resulted from new service models or new practices in service delivery. Outcome evaluation could only occur some years after the service reforms had occurred. However, a reflection (at 2014) on the changes made to the central part of Tasmania is that it is a thriving and lively community health service, some five years after it ceased providing aged care and inpatient services.

There was a comprehensive project and program management reporting process that was centrally coordinated for the duration of the active implementation phase, which ran from October 2007 to May 2010, and included providing training to approximately 100 designated contact staff in the method and use of the project management templates. There was a reasonable level of documentation completed for a total of 134 projects, including 86 per cent completion of written project briefs and 69 per cent of regular completed monthly progress reports. The central THP management group kept the reporting as simple as possible, given that many of the initiatives did not have dedicated staff to oversee them. Reports were collated on a monthly basis into a Gantt chart, and these were then available publicly in summary form as Quarterly Progress Reports (DHHS, 2009c).

In June 2009, designated contact staff for each of the projects under the THP was asked to undertake a self-assessment of the performance of their project against the following health planning objectives (DHHS, 2007k, p7), that aimed to ensure health services would be:

- as close as possible to where people live, providing services can be delivered safely, effectively and at an acceptable cost
- appropriate to community needs
- client- and family-focused
- integrated through effective service coordination and partnerships between providers
- designed for sustainability.

Results suggested that 75 per cent of project managers had explicitly included consideration of the objectives in the development and implementation of their project initiatives. As a rule, however, designated contact staff did not believe that they had attained the achievement of planned program objectives because they generally represented longer term significant changes. For example, some of the project to improve patient and community transport had improved access, but had not necessarily impacted on inequity of access (DHHS, 2010b).

Collecting data on the establishment of new ways of operating or responding is difficult, and making it meaningful is even more complex. What was established at the outset of the development of the PHSP was the idea of a 'report card'. The Secretary of DHHS at the time of the early development of the THP was former Secretary of the Education Department. In principle it was a positive and transparent mechanism to share information on progress that had been seen as successful for education. Where this was difficult to achieve in health, however, was that a lot of the primary and community sector did not have adequate reporting systems in place beyond paper-based methods, and so the collation of even the most basic performance reporting was generally poor.

There were also two intermittent summary evaluations provided to the THP, the second of which included the following:

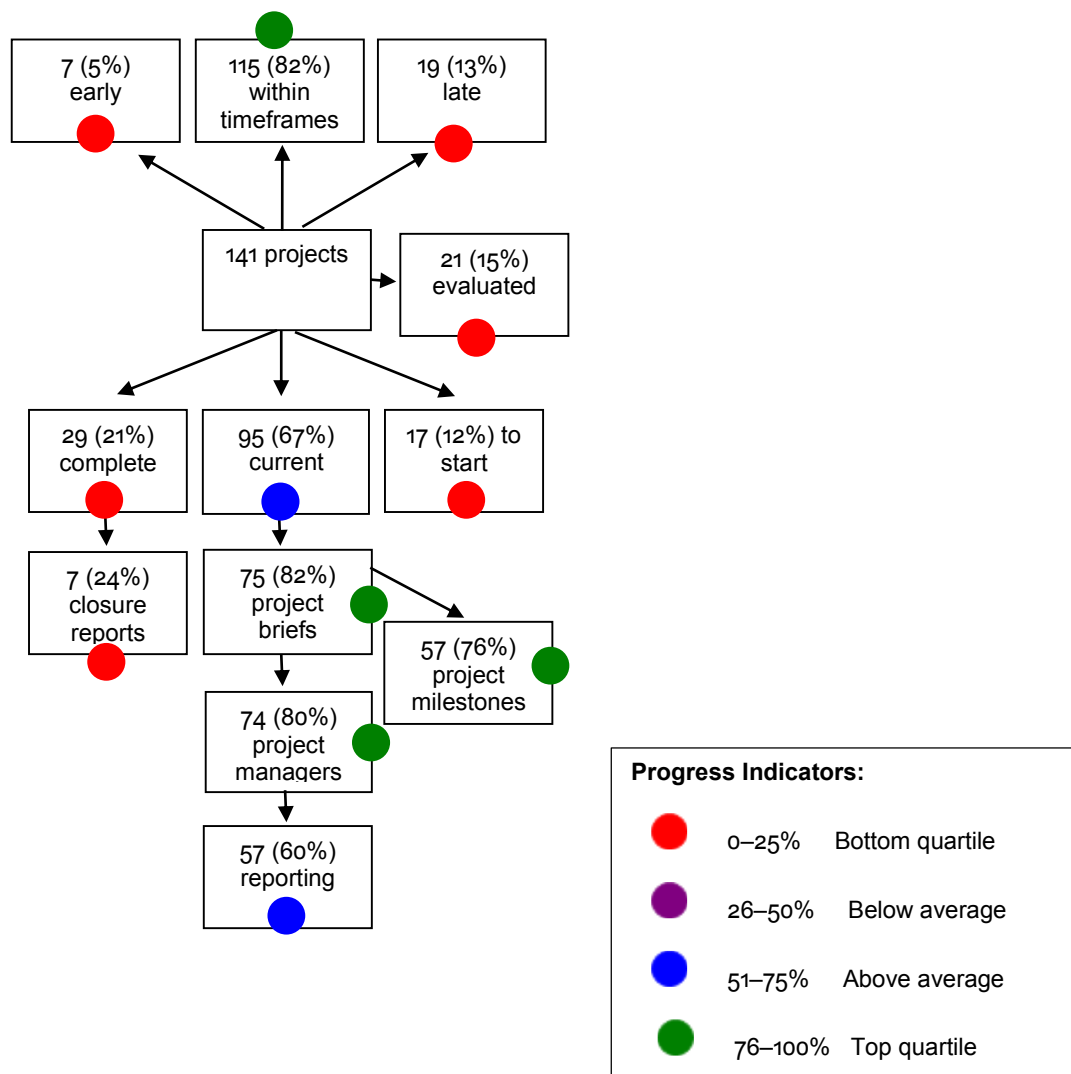
Evaluating the THP Program of Projects: April 2009

Activity

- As of April 2009 there are 141 separate projects or subprojects in Tasmania's Health Plan.
- Of these, 21 per cent have been completed, 67 per cent are currently underway and 12 per cent have not yet begun.
- Only 5 per cent of projects commenced or finished earlier than expected, 82 per cent are running within their expected timeframes and 13 per cent are running late.

Validation

- Only 24 per cent of completed projects provided a closure report.
- Of the current projects, 82 per cent have provided project briefs and 80 per cent have been allocated project managers.
- 60 per cent are providing monthly reports.



Probably the most reliable source of impact and outcome data was seen to be the State of Public Health Report, which is drawn from the Population Health Survey, AIHW and other national data compiled into the Health Indicators Tasmania report (Population Health, 2008, 2013). The State of Public Health Report is tabled in Parliament by the Director of Public Health every five years.

There was a collation of a variety of comments from different leaders in the implementation of the Tasmania Health Plan in the THP Anniversary Report December 2009. Firstly, a statement on behalf of the Minister for Health:

‘Two years on and Tasmania’s health system is clearly on the mend if not yet fit and well. Ms Giddings says the two-year milestone gives cause to reflect on the progress and impact of Tasmania’s Health Plan.

‘When we launched the Plan in May 2007 we had one clear objective: to deliver a high quality, sustainable, responsive and integrated health system to meet the future needs of the Tasmanian community,’ Ms Giddings says. ‘Tasmania’s Health Plan is based on providing services as close as possible to where people live, as long as quality and safety standards are met in all cases. Unfortunately, because of Tasmania’s small but widespread population it is not possible to provide specialist care in every hospital. To do so would compromise standards and put lives at risk.’

Ms Giddings says it was clear from the outset that confronting difficult decisions was a necessary but challenging task. ‘Back at the launch of the Plan, I said that for almost 50 years governments of all stripes had tried to grasp health care reform in this state and that they, despite best intentions, had found it almost impossible to tackle the big issues.’

And later in the same document:

‘Besides the bigger ticket, headline items like the new Smithton hospital, many more behind-the-scenes components of the Plan are either completed or making good progress,” Ms Giddings says. ‘Planning helped us lift our heads to the horizon to see what was coming our way. Two years ago that revealed an alarming vision. It still does; but we are now in a much stronger position to cope with it. I am convinced that beyond the horizon lies a brighter, healthier future for all Tasmanians.’ (DHHS, 2009)

The Deputy Secretary spoke about the importance of community and consumer engagement in a statement issued on her behalf:

Systematic consumer and community involvement in decision-making gives health and human services policymakers a richer view of how the system

performs in the real world. It is recognised internationally that actively engaging consumers and the community in service planning and delivery promotes better individual and community outcomes.

Department Statewide System Development Deputy Secretary says the more control individuals have over their circumstances, the better their quality of life and sense of wellbeing. “To achieve better outcomes it is important to hear the voices of people who use our hospital, disability or other health and human services,” Ms Bent says. “Initially, the department is asking the public how they prefer to get involved in the ongoing consultation process so we get it right and make it meaningful from the outset,” she says.

“Consumer and community engagement is not an end in itself but an important step towards creating more effective health and wellbeing services for all Tasmanians. Consumer and community engagement will not mean everyone will get everything they want all of the time, but it will mean people will hear the reasons behind decisions and have a real chance to shape their services”.

And, finally the DHHS Secretary put the THP in context with health policy nationally and internationally in this statement issued on his behalf:

Along with most western countries, Australia faces major challenges in meeting increasing health demands from citizens. The costs of health care – in particular hospital care – are rising steeply, critical workforce shortages persist and there is a mismatch between services and community needs.

Department of Health and Human Services Secretary says facing these circumstances, health care systems around the world are shifting to better integrated services that recognise that multi-skilled team-based workplaces are essential and that technology is vital to success.

“In Australia we’re on a bold journey, but thanks to Tasmania’s Health Plan we know where we’re going and are getting better all the time in measuring the progress we are making.

Modern health care is about joining up services into a seamless whole for the benefit of our patients and clients, even though behind the scenes their journey may involve many health professionals across several services.

Work under Tasmania’s Health Plan has improved and expanded many services and this work continues. A major focus now is to integrate acute hospitals, community hospitals and primary health care services under local area management.

This is not about going back to regional hospital boards as it is vital that our statewide approach to health care remains. Integration is about getting doctors, nurses and health professionals to work together towards a common goal. It will overcome overlaps and close gaps in services by improving communication and cooperation. We must break down the artificial barriers that exist between primary and secondary care to deliver a more streamlined service that will make life easier for patients, clients and staff alike.

...In Tasmania our journey begins with integration of primary and secondary health services through a move to area health services, which is in line with the area-based management approach common to health and human services, education and police – a vital part of the plan for a more cohesive approach to government and public services”. (DHHS 2008g)

Each of these examples of the voices of the key leadership actors demonstrate the different dimensions of communication focus that were active in getting the agenda set for the implementation of the THP, and the inclusion of a focus on broadening the clinical health perspective to include a focus on people and communities and on a primary health approach.

This chapter has drawn from a variety of material drawn and collected from within DHHS in Tasmania including the documented minutes of meetings and briefing notes for senior staff and the Minister. The combination of these documents, together with authors own notes, draw on the coordinative development of a discourse for a comprehensive approach to primary health that some of the key actors had been engaged with for some time. The Tasmanian State Government election in 2006 provided an opportunity for the policy to be developed, however, it was perceived as less of a problem than some of the more costly and timely challenges that were facing the hospital sector. The key policy actors used the political window (to draw on the Kingdon analogy) to draw attention to the concerning decline in a rural workforce that was being necessarily augmented by locum staff. When the opportunity for primary health policy was defined as a problem in this way, there was a shift in the discourse into the communicative sphere. The public and political narrative of ‘pushing the health system to the brink’ was a powerful metaphor for action.

There is value in analysis of the potential factors that could have contributed to getting the PHSP onto the agenda by considering the relevant scholars. Haas (Haas, 1992) argued that the cause and effects of complex problems are articulated through the networks of knowledge-based experts who frame the issues that are debated, but that may assume a rationality of process. Stone (Stone, 2002) and Kingdon (Kingdon, 2003) found less order in the processes and that problems continued to be framed and re-framed until an alignment occurs with a window of opportunity. An

alternate view would see that the endogenous deliberations through the key actor networks within government (in this case the PHSP leadership group) were deliberately adapting and innovating the ideas and the discourse (Hay, 2001; Campbell & Pederson, 2004; Schmidt 2002)

CHAPTER 5

5 A tiered service delivery model

This chapter is the second of the three case chapters and the material has been selected to highlight the complexity of the environment in which decisions were being made, with multiple sub institutions and actor groups within the DHHS, and the deliberate agency of the THP leadership group to affect change. The institutionalism literature reviewed in Chapter 2 found DI to be the most relevant for understanding the processes of communicating change. This is because, according to Schmidt, the “institutions of DI [in contrast to the more rigid institutions of HI, SI and RI]...are simultaneously constraining structures and enabling constructs of meaning, which are internal to sentient agents whose ‘background ideational abilities’ explain how they create and maintain institutions at the same time as their ‘foreground discursive abilities’ enable them to communicate critically about those institutions, to change (or maintain) them” (Schmidt, V 2010a, p4). This chapter achieves an understanding of this complexity through the analysis of the communication processes that occurred during the implementation of the PHSP within the THP.

In order to better understand these processes, the chapter includes documents and material relating to the early implementation of the PHSP (DHHS, 2007h) starting with the launch of the THP in May 2007 through to the end of 2009. With reference to the core research questions, this case study gives particular consideration to the “agents of change”, not only in terms of the formal positions held institutionally or within particular networks, but also in terms of the way the actors communicate and convey the ideas for change and the extent to which particular ideas are legitimised or contested. The ideational features of DI are useful in the consideration of how the policy ideas are variously permeated and represented through the different sub-sets of actor and institutional networks.

The diversity and volume of actors and institutions are identified in this chapter, and many of them are within the DHHS. Each of these groups of actors and institutions has their own sets of interests and ideas, and reacts differently to the new policy ideas for tiered service delivery. The THP leadership group is a small group of actors most of whom started as the PHSP leadership group out of the CPRH in DHHS. This actor group and the other key sub-sets of actors and institutions within the DHHS were described in Chapter 3, Figure 7. These, and the actor and institutional groups external to government, are identified in Figures 15,16 and 17 of this Chapter and their relative understanding and acceptance of the new service model is articulated. This observation is insightful to the different ways that the same ideas are interpreted as a discourse of change amongst actor groups and institutions that have different frames of reference, interests or professional groups.

The processes of communication in DI are explained as consisting of both ideas and discourse and these differ in both generality and type. “[...] cognitive ideas are constitutive of interests and normative ideas appeal to values. Discourse serves not just to represent ideas but also to exchange them, through interactive processes.” (Schmidt, VA 2008b, p321). These interactions were most actively productive at the local level between actor groups and insititutions and can be distinguished as vertical and horizontal communication processes. Vertically, the relationships between the formal institutions of the hospitals and the primary care sector that was managed by the State were being brought together to form area-based regional services. This was happening at the same time as the changes within the primary health care sector were being advanced. While there is evidence of some traction in the ideas gaining hold, there is less evidence of changes in practice occurring and significant levels of confusion and uncertainty about the proposed changes that were expressed by the affected staff. At the horizontal level, the primary health system includes multiple institutions and actor groups made up of community sector organisations, aged care and private general practice organisations. The actors and institutions in these and in local government were, at times, struggling to make sense of what was happening and this impacted on the extent to which the ideas of primary health delineation through a new tiered service delivery model were either heard, or acted on at the local level.

The chapter is structured into four sections following the same structural outline as the previous chapter. The first section establishes the context for the proposed tiered service delivery model. The next section describes the institutional collaboration in which the conceptual ideas were developed and tested; including the organisational service arrangements that were changing at the same time as the implementation arrangements for the PHSP was being established. The third section of the chapter considers the complexity and confusion that was apparent during the engagement between the key THP actors and the actors and institutions they were working with. The final part considers whether there was any impact on outcomes, including the perceptions of change, finding that as Braithwaite (see Chapter 1) said “[...] Restructuring is so pervasivethe evidence for this making a difference, let alone demonstrably improving productivity or outcomes, is surprisingly slender.” (Braithwaite et al, 2005, p542).

The following material identifies the new service model and is drawn from the meetings and briefing papers that were introduced and tested with relevant organisations and groups in the lead up to the launch of the plan. The model was described in the PHSP as follows (DHHS, 2007h,p5-6):

“A tiered service delivery model establishing an integrated network of primary health services across Tasmania has been applied to all services delivered by the Department of Health and Human Services (the Department). Tiers 1–3

represent primary health service sites and have been developed considering current and future needs, specifically:

Primary Health Services Plan

- population trends and levels of community need
- distance from other services
- sustainability considerations such as cost and workforce availability.”

The differential features of each of the tiers are described in the PHSP as having been developed as a new discourse that ascribed the delineation of responsibilities from the local community health centre through to the regional hospital outpatient services. This detail in the PHSP, when it was launched in 2007, was built from the preliminary policy material that had been established through eighteen months of regional and local consultation, demonstrating the depth of policy thought that the key actors (who principally became the THP leadership group) had already given to the fundamental health policy change they were pursuing. There was a perceived legitimacy in the language, and a defined ‘reality’ through the explanation of what each part of the new health system structure would provide and how it would professionally connect and refer patients.

However, having gained authority to take action, the process of gaining traction and legitimacy for the implementation of the new service model was more complicated. The development of the discourse within the coordinative spheres of government agencies and into other organisations and networks required multiple and sophisticated communication methods and techniques. The experiences were similar to the uncertainty, paradoxes and ‘political rationality’ described by Stone (2002), or part of what Bauman refers to a ‘liquid modernity’ (Bauman, 2000). This communication about ideas and policy change for new service model delivery was occurring in a context of institutional leadership change, structural service change, and the push and pull of frontline staff within their communities. At the same time, political tension within the State’s Cabinet forced the Health Minister to be more risk averse.

The subsequent challenges to the legitimacy and acceptability of the proposed policy changes are described for each of the institutions or actor group with a direct relationship to the PHSP implementation process.

5.1 Establishing the context for a new service model

A new service model was proposed to secure the role of community and rural health facilities as a key resource for their local community, provide clear delineation guidelines for the delivery of safe and reliable health services in Tasmania, and strengthen local linkages between general practice, the DHHS primary care sector, community sector organisations and local government. In addition to identifying three tiers of delineation, the new service model also articulated the bridging point between primary and acute services with the establishment of a fourth and new band of services that would be called Integrated Care Centres.

The Tasmanian population has a significantly higher rate of chronic conditions than other jurisdictions in Australia. This is in part because it is ageing at a more rapid rate than the populations of other States and Territories, and also because of the disproportionate number of people with low socioeconomic status, which impacts on access to services as well as capacity to respond (DHHS, 2008, 2013) to the management of symptoms or the availability of support. Chronic diseases such as heart disease, stroke, cancer, emphysema, depression, dementia, diabetes, asthma and arthritis create significant health problems and are a major cause of premature death, as well as avoidable hospitalisation.

These factors in combination create a very different environment for primary health service needs from that of the acute sector services. There is a complexity in the range of actors and institutions that requires more than the expectation that generalist services at the local and community level can prevent hospital admissions or minimise the impacts of chronic conditions on the acute care system. Models of care need to take account of what is happening in all parts of the system, together with the interests of people who may use services, and the patterns of their needs and behaviours.

Chronic disease management increasingly relies on care in the community, with patients being supported to understand their condition, manage it actively with professional support and seek assistance at an early stage if their health deteriorates, before hospital admission is necessary. The Clinical Services Plan Issues Paper, (DHHS, 2006h) like the Primary Health Services Issues Paper, preceded the THP as a notional white paper²⁰, stating that most modern health care systems have increased the range of home and community-based services, reserving hospital beds for those who require specialist care that cannot be provided in other settings. This gave a context to the idea for a new service model within a broader family of health policy reform, and the theme was followed through to the

²⁰ A white paper is a formal discussion paper provided by governments for the public to comment, usually it is used to share details of a proposed policy direction before it is implemented.

plan itself with the Tasmania Health Plan Summary document noting that “Tasmania is yet to address this challenge” (DHHS, 2007k).

The PHSP (DHHS, 2007h) proposed a new tiered model of service provision that would strengthen the position of community and rural facilities and provide clarity for staff and communities regarding the delineation of service provision. The distribution of service types within the proposed tiers would reflect the complexity of service provision, the extent that other services need to be involved or other support provided for safe and reliable practice, and the service’s geographic coverage (DHHS, 2007h, p57).

The complexity of the new ideas proposed in the service model cannot be underestimated. As an email in September 2006 from the Deputy Secretary, Community Population and Rural Health (DHHS, 2006b) stated:

“The process as it is mapped out is not a simple one: the task is not simple if we are to achieve a plan that provides us with a 10 year time vision but also provides guidance on how services are to be delivered on the ground. Important to get it right, considering that it will be used as a rationale for significant reform/change process and where Government is being asked to make decisions about critical service issues.

While the plan identifies statewide strategic priorities and the actions needed to implement these, it has to do more than that. It needs to provide an objective framework through which information can be evaluated and arguments for change mounted. This will be subject to considerable scrutiny.

[...] we are developing a mechanism for assessing the relative need of communities across Tasmania. We need to assess where resources are allocated currently and develop a funding model that would be the basis of equitable funding distribution in the future.

[...] new service delivery will be based on local primary care networks, across government, private and community sector, linked in to local government and with formalised links back to the major hospitals. Hub and spoke models will be the basis for this thinking.”

This is an example of the coordinative processes at work with extensive interaction between the internal executive groups and individuals in meetings and discussion about what was proposed and why, and how it would all potentially work. As the construction of the ideas was articulated at the executive level, they were also being developed through workshops, meetings and the circulation of discussion papers for consideration.

There were multiple actors and institutions involved with the development of the PHSP and its implementation. The following figure illustrates some the groups of institutional relationships with the DHHS Secretary who was responsible for the overall THP and the formal contact point with the Minister for Health. Following this simple stakeholder map, Figure 15 lists the actor groups and institutions involved, and then Figure 16 expands to describe the impact and receptivity to the ideas proposed by the tiered services model in the plan. Figure 16 uses examples of actors and institutions from each part of the map in Figure 14, and identifies the relevance and understanding of proposed tiered service model and the challenges to legitimacy and implementation from each of their perspectives.

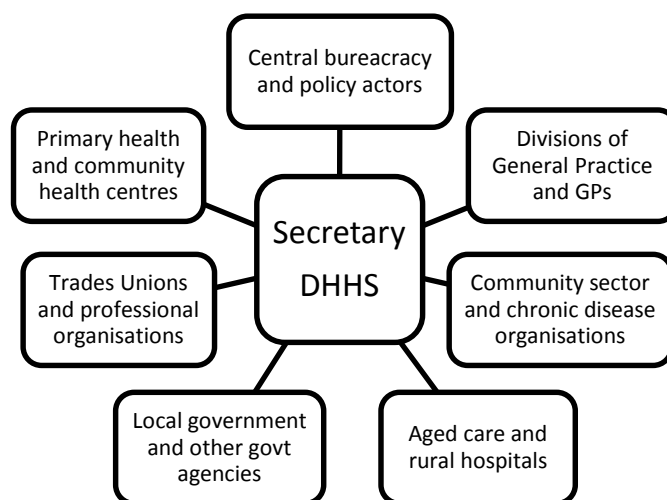


Figure 14 Simple stakeholder map of the groups that the DHHS Executive included with the proposed tiered service model for primary health

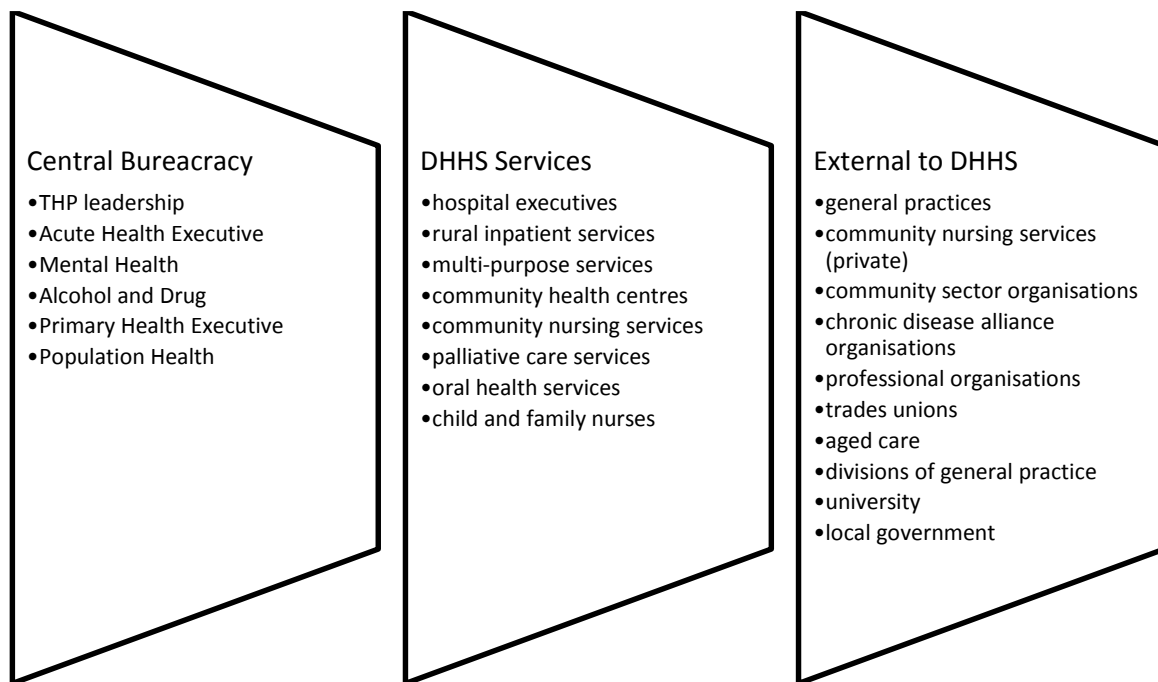


Figure 15 Groups and institutions directly involved with the proposed tiered service model for primary health

| Institution/actor group | Relationship with State Government DHHS Tasmania Health Plan Implementation | Relevance of proposed tiered service model | Challenges to legitimacy and acceptability of proposed tiered service model |
|---|--|---|---|
| <i>DHHS Secretary</i> | Leadership relationship with elected members of government | Core platform for THP to address the burden of chronic disease | Opportunity to relieve pressure on acute health services and gain \$ efficiencies |
| <i>THP leadership</i> | Leadership group for the THP (PHSP coordination was combined into THP leadership group by 2008) | Leadership of ideas to address the burden of chronic disease by increasing the investment in primary health, and broadening health policy to a more social model | Concern that the complexity and resourcing requirements for change are not met, timeframes are tight |
| <i>Acute Health Service Executive</i> | Internal DHHS and represented on THP leadership group | Involved more with the clinical services parts of the THP, and the pressures on emergency dept and elective surgery lists together with lack of statewide clinical consistency | Not seen as biggest priority with the more 'significant' challenges of acute and clinical care |
| <i>Mental Health Services and correctional health</i> | Internal DHHS with strong community client voice, and contracts with NGOs (early involvement with the PHSP) | Involved with ideas development and need for stronger community sector for early discharge and hospital avoidance | Opportunity to collocate and be involved with the highest tier of service model, and potentially to offset the lack of capacity to provide services for local and rural health access |
| <i>Alcohol and Drug Services</i> | Internal DHHS, mostly contracted out, with methadone program provided by State (early involvement with the PHSP) | Involved with ideas development and need for stronger community sector for early discharge and hospital avoidance | Not really interested |
| <i>Primary Health Services Executive</i> | Internal DHHS, key leadership group for PHSP implementation to succeed | Involved with ideas development and fit with new primary health networks and partnerships locally that will strengthen primary and community health policy | Implementation seen as a challenge with primary health model not bedded down |
| <i>Population Health Services</i> | Internal DHHS, key leadership group for development of policy for implementation | Involved with the development of ideas and support the investment in primary health, particularly the links to broader preventive health opportunities | Strong alliances with the implementation of ABHI, supportive of the Primary Health Coordinator role and links to the determinants approach |
| <i>Hospital Executives</i> | Internal DHHS, key leadership group for THP implementation to succeed (less interested in the PHSP component of the THP) | Peripherally interested in the tiered model as means to strengthen community take up of patients when discharged, some interest in tier four integrated care if funded by community and private sector or GP Divisions/Commonwealth | Concerned that any development in strengthening community sector has to be done separately and not from acute funding pot which is too tight |

| | | | |
|---|---|---|--|
| <i>Rural inpatient hospitals</i> | Internal DHHS. Mixed alliance, mostly state funded with local community involved and some with advisory boards. Key actors for PHSP implementation to succeed | Want more resources for primary health, concerned with rural population and service decline, see tiered service model as criticism of small rural hospitals, signalling intention to close them | Lack of understanding leads to lack of trust and belief that change means loss of services |
| <i>Multi-purpose services and centres</i> | Internal DHHS. State and Federal Aged Care funding, mixed alliances, and all have advisory boards. Key actors for PHSP implementation to succeed | Mixed levels of understanding of tiered services model, and some similar thinking to rural inpatient services | Lack of understanding leads to lack of trust and belief that change means loss of services |
| <i>Community Health Centres</i> | Internal DHHS, mixed alliance and some with strong community voice and advisory committees. Key actors for PHSP implementation to succeed | Centres vary greatly in local leadership and capacity, with some mostly a collocation of many different service providers (e.g. Glenorchy and Kings Meadows) and others with a strong collaborative approach to meeting local needs (e.g. Huonville and Westbury) | Where there is understanding or capacity there is strong support for the tiered model to better explain, strengthen and develop the community health centre model and its potential |
| <i>General Practices</i> | External to DHHS. Medicare funded by national government, with some rural practices supported by the state and local government. Key actors for PHSP implementation, but no active engagement with the THP, or the PHSP in particular | Vary greatly, with some small practices that operate tightly with each other and their practice manager to meet their patients' needs, and increasingly, the establishment of a corporate model which is less responsive and more likely to employ doctors and operate on stricter business terms; some rural and urban practices actively engaged and interested in the tiered model | Marginal engagement, but where it exists it is generally supportive, especially where there may be better opportunities for point of care testing or community pharmacy and radiology services, and better discharge information/linkages with specialist services |
| <i>Community Nursing Services</i> | Internal DHHS. Some nurse clinics, some based in Community Health Centres. Key professional groups of actors for PHSP implementation to succeed | Mostly an older workforce with established patterns of practice that are reluctant to change (e.g. setting up nursing clinics in Launceston and Hobart to reduce home visits took three years and industrial action, despite obvious want from clients) | Generally a lack of understanding or interest in the tiered service delivery model. There is a general resistance to change, and if anything there is a concern at potential threat that practice nurses in general practice (cost less to employ) may take their jobs |
| <i>Palliative Care services</i> | Internal DHHS, not directly impacted and engaged with PHSP | Generally supportive of the tiered model and capacity for more people to die 'well' as close to home as possible | Supportive |
| <i>Oral Health services</i> | Internal DHHS, some based in Community Health Centres. Not directly impacted and engaged with PHSP | Generally supportive where there is any interest | Supportive |

| | | | |
|---|--|---|--|
| <i>Community sector organisations</i> | External to DHHS. Mixed alliances, mostly service providers funded by state or nationally. Not directly impacted and engaged with PHSP | Unless directly relevant, little understanding of proposed tiered service model. Social determinants of health have relevance and a community-driven model that develops resilience, self-management and efficacy | Change is seen as loss of services |
| <i>Chronic Disease Alliance organisations</i> | External to DHHS. Alliance includes Heart Foundation, Diabetes Australia, Cancer Council, Arthritis Tasmania, Stroke and Kidney Foundations. Key interest in the PHSP implementation | Little understanding of tiered service model; interested in funding for new programs for prevention, and some have interest in funding for common behavioural risk factors and hospital avoidance | Frustration at slowness for change to occur and lack of responsiveness to implementing new programs for smoking cessation and health promotion |
| <i>Professional organisations</i> | External to DHHS. RACGP, PHA, HPA, ACHSE, AHHA. Membership of many staff within DHHS, and engaged with the THP leadership as partners | Some Tasmanian branches were active during implementation phase and commented on tiered model e.g. HPA and AHHA were actively supportive of central policy leadership during federal takeover of the Mersey and in the general advancement of primary health policy | Generally supportive, except where changes would impact on members |
| <i>Trades Unions</i> | External to DHHS. ANF, AMA, HACSU and CPSU. Membership of many staff within DHHS, and engaged with the THP leadership as partners | Tiered service model is positive only if jobs are kept and not changed. Could introduce new work roles such as nurse practitioners, therapist and nurse assistant positions, none of which are supported by unions even where they improve career pathways | Resistance to change |
| <i>Private sector organisations</i> | External to DHHS. Pathology, radiology services, private hospitals and health insurers. Not directly engaged with the THP | Most private services not viable to be provided in rural communities and tiered service model provides rationale to exit outstanding obligations | Generally supportive, because little impact on mostly urban based services |
| <i>Aged care services</i> | External to DHHS. Mostly faith-based not-for profit, nationally funded | Tiered service model represents final removal of the State from provision of aged care services except for multi-purpose services | Concerned about financial viability of changes and transferred liability to their organisations |
| <i>Divisions of General Practice</i> | External to DHHS. Mixed alliance, mostly policy partnership, nationally funded Active partner with the THP leadership and key advocate for PHSP implementation to succeed | Involved peripherally with the development of ideas, and proposed tiered service model fits with national and international policy perspectives on strengthening primary health care | Opportunities to fill gaps in market failure by the State, critical of state's lack of speed, innovation capability to respond to change etc. e.g. overlap between community and practice nurses |

| | | | |
|-------------------------------|---|--|---|
| <i>UTAS Faculty of Health</i> | External to DHHS. Workforce development, shared positions, Partners in Health | Involved peripherally in the development of ideas, particularly for the conceptual thinking for a fourth tier of Integrated Care Centres; relevance for new workforce, multi-professional care, service integration and improving population health outcomes | Supportive but even more of a leviathan than the State in terms of responsiveness |
| <i>Local Government</i> | Some community services including public health functions | Varies greatly; some larger councils are actively engaged and supportive of primary health networks and relationship with primary health coordinators where this has occurred is seen as positive in relationships between local and state government; already an existing relationship with environmental health, and some community development officers are actively working with local community health workers | Patchy, but positive where there is capacity, particularly for the ideas of primary health networks |

Figure 16 Policy actors and institutions relative understanding and concern

This illustrative analysis of the relative response to the proposed tiered service model, and the consideration of its implementation, can provide some understanding of the complexity of the relationships and interests at stake in the coordinative sphere. Figure 17 reveals the dynamic complexity in practice through the detailed consideration of each of the various lenses and perceptions of response to the proposed tiered service delivery model in the THP. This accurate review of relative understanding is significantly simplified, because in reality the range of participation and the relative significance of actor and institutional roles and influences are more complex. Actors can operate individually, aside from the collective normative position of their institution, and a variety of subsets of actors are evident from within the wide range of organisations represented in, for example, the group of rural in-patient and multi-purpose services and centres in Figure 17. To expand on this further, several of the rural inpatient or multi-purpose service facilities in Tasmania have advisory boards with a community membership in addition to a variety of associated volunteer fundraising groups. These facilities and their boards commonly have active support from the respective local government that could include, for example, financial incentives to retain a general practice by providing local accommodation.

There is a further level of the tiered service model that has not yet been introduced to this case chapter. Integrated Care Centres were not originally included in the PHSP, but were identified as a fourth tier of the service model within the first year of implementation, and in collaboration with the Clinical Services plan as follows:

One of the key initiatives in the Primary-Acute Integration Workstream of the Primary Health Services Plan and Clinical Services Plan is the development of Integrated Care Centres. These are to be developed jointly by Acute Health Services and Community Health Services. (DHHS, 2007a)

This was in recognition of the need to provide services for people with chronic conditions at the interface between acute and primary care. The intention was to provide better access to, and linkages with, specialist interventions as an alternative to hospital-based care. The concept of an Integrated Care Centre was uniquely contextual to Tasmania, and drawn from a similar type of service model that was early in its establishment in the Department of Health in New South Wales (2006). Similarly, Victoria (Department of Health and Human Services 2006a; 2006b), Western Australia (Department of Health 2007) and New Zealand (National Health Committee New Zealand, 2007) were, at that time, developing hospital avoidance programs, some of which included new models of integrated community-based services (DHHS, 2007a). More information about the Referral and Information Centre model in the Hunter Valley region of NSW identified that it had some similarities to the intention of the Integrated Care Centres proposed for Tasmania.

These inter-state and international influences and policy models were developed through a number of different discourse mechanisms initiated by the THP leadership group and other key internal DHHS sub-groups such as the PHS Executive and Population Health. One mechanism was through DHHS membership of national organisations such as the AHHA,

the HPA and the PHA that were advocating for central policy leadership and consistent national policy for primary and community health services. Population Health responsibility for the implementation of the ABHI initiative meant that they saw the value of the proposed position of a Primary Health Coordinator. They had links with Population and Public Health Services in other jurisdictions and through inter-state meetings and visits they were particularly positive that the proposed approach was consistent with Victoria and would strengthen local community intersectoral linkages to improve the determinants of health.

The THP leadership group initiated contact with other jurisdictions where potentially transferable ideas had been identified. Visits were organised for relevant local Primary Health Services managers and community nursing staff to NSW, Queensland and Victoria to see various hospital avoidance programs, and integrated community based services. The emphasis for change was to reduce the burden of chronic disease by increasing the community effort, but the THP leadership group were concerned that the complexity involved to successfully achieve this was not reflected in the resourcing and not recognised well enough by the government overall. Primary Health Services Executive were critical for the successful implementation of the PHSP. They experienced the constraint of unrealistic timeframes and resourcing for managing change and found it challenging to make the visits interstate to see first-hand what was being done elsewhere.

The locations for the proposed Integrated Care Centres were identified and the intention was to provide significant day services for people with chronic and complex health or social care needs, including renal dialysis, chemotherapy and diabetes care, closer to where they lived. The PHSP described them as:

Integrated Care Centres: Traditionally, settings for the delivery of health care have been determined largely by their sources of funding. State-funded health services have been provided mainly through State-owned facilities which often have been established in relative isolation from Australian Government or privately-funded health care providers such as GPs, private hospitals, private community nursing services and private allied health services.

There has been increasing recognition of the urgent need to integrate services to reduce gaps and duplication and ensure client access is unimpeded by funding or organisational boundaries [...] they may be stand-alone facilities; colocated with acute hospitals; or incorporated within acute hospitals. (DHHS, 2007h)

And the Clinical Services Plan described them as:

Integrated Care Centres are facilities that:

- are designed and managed specifically to accommodate a range of health services that provide efficient, integrated care regardless of who funds, owns or provides each element of the services a client accesses

- operate under a philosophy which is less interventional and oriented towards care in the community rather than institutional care
- provide greater certainty of access for clients because they focus on non-emergency services including a broad range of non-admitted primary, secondary and tertiary services, short-stay elective services and specialised sub-acute services. (DHHS, 2007i)

The intention was to implement a combination of service reconfiguration, linkages to specialist services, and to increase the practice of health promotion within the secondary levels of care. An example of this would be to establish a focus on behavioural and lifestyle prevention and self-management programs aimed at patients and their families. This would potentially develop the organisation and professional skills within the Integrated Care Centres for the practical implementation of patient focused health promoting approaches. This focus on the fourth tier of the service model would, as it was intended, have a flow on impact for the facilities and services in Tiers 1–3.

Tier 3 sites may include integrated services operating across the acute hospital and community care interface. In the context of the urban-based Integrated Care Centres they may include inpatient aged care and rehabilitation services.

In Tier 3 sites, in addition to Tier 1 services, the following could be provided according to need:

- specialised palliative care
- hospital in the home (contracted with acute hospitals)
- inpatient and outpatient rehabilitation
- aged care assessment
- alcohol and drug services
- oral health services
- specialist mental health care
- dietetics
- specialist diabetes education
- continence service
- medical oncology
- satellite renal dialysis service
- same day surgery

- more extensive health promotion and prevention programs.
(DHHS, 2007h)

This section has provided an analysis of the key actor and institutional groups engaged within the central bureaucracy of the DHHS that were responsible for the engagement and development of the PHSP and subsequently the whole THP implementation. Consideration has been given to the different ways that the new service model was articulated and, in Figure 16, to the ways that the many actor groups and institutions understood or supported the proposed service changes.

5.2 Institutional collaboration

In the latter part of 2007, planning started toward the implementation of each of the plans. Governance arrangements were delegated to the Deputy Secretary level leadership. The Deputy Secretary charged with implementation of the PHSP had state-wide responsibility for CPRH which included the following services: Primary Health and Community Health, Mental Health, Alcohol and Drug, Oral Health, and Population and Public Health, including Cancer Screening and Control (see Figure 9 Chapter 4 for the DHHS Organisation Chart for 2005).

Primary Health Services were still consolidating a relatively new structure that had been approved in April 2006, but had taken until August 2007 to successfully recruit to the key positions of regional managers (Community Health Services Group, 2007). This was because these were new Senior Executive Service positions that needed approval by Cabinet to be created and appointed following the formal recruitment processes. The new structure included seven primary health coordinator positions which were crucial to the development of local primary health networks, as well as to support staff and communities with understanding, and implementing the new model that emphasised working in health promoting ways.

The intention was that primary health coordinators would support the new and proposed regional primary health management structure by fostering partnerships at the local level. This would bring all of the different actors together including all levels of government, the private and community sectors, general practice and service providers from other government agencies such as education. It was intended that the partnerships would link all of the local service providers and enable greater involvement of the community in health service planning and improvement.

This was at the centre of the big ideational turn, intended to practically implement the broader model of comprehensive primary health policy that combines the health and social models - engaging with and responding to the local population and community needs, and their patterns of activity and movement. The critical success factor was vested in the new

role of primary health coordinators. Principally these staff were administrative managers most of whom had a nursing or allied health professional background.

They (the primary health coordinators) will:

- Lead the development of coordinated and integrated primary health services within designated municipal areas
- Work with local councils and other key stakeholders to develop a planned and coordinated approach to providing primary health services
- Develop partnerships with the goal of strengthening the links between primary health, community health services and the local community. (DHHS, 2007h, p66).

The overall governance for implementation of the PHSP was initially driven by the PHSP Coordination group (refer to Figure 16) that was chaired by the Deputy Secretary for CPRH. With a small budget relative to that identified for the Clinical Services Plan, the Primary Health Services Plan for implementation was to draw a small high-level team together and to plan implementation utilising existing structures and leadership wherever possible. For the initial governance structure for the Implementation of the THP as at December 2007, see Appendix 1.

The PHSP Implementation Plan, in the first instance, organised and structured the strategies into five work streams of action as follows:

- Primary Health Focus
- Primary Acute Interface
- General Practice
- Primary Health Partnerships
- Workforce sustainability

There was a coordination and evaluation function provided centrally by a leadership team supporting the Deputy Secretary CPRH, and a further work stream – Strengthening DHHS Capability – that was identified because of interdependencies with other areas, but recognised as outside of the scope of the PHSP Implementation Plan.

By the time the PHSP Implementation Plan was accepted by the DHHS Secretary, the first organisation change occurred that included changing the title of the Deputy Secretary to that of Community Health. This better aligned with the equivalent position of Deputy Secretary Acute Health Services, but initiated the discussion of whether it was to include primary health. There was much more organisational change to come as the year

progressed, but further analysis of the governance arrangements for the PHSP implementation will be covered first.

Each of the five work streams had a key nominated leader and oversight of several projects each of which had been assigned to a staff member depending on the intended extent of the initiative. Each of the work streams was supported by an existing governing body such as the Primary Health Executive Group, which held a regular monthly management meeting, or Partners in Health, which was an established formal partnership between UTAS and DHHS with a management group that met regularly. The nominated leader for each work stream was responsible to the existing governing committee or body and supported by the leadership team who provided overall coordination and evaluation of the implementation of the plan. Some projects overlapped with others in other work streams, but were allocated to the stream of greatest relevance so as to effectively manage the leadership and coordination within the constraints of the resources available.

| Work stream | PHSP Coordination and evaluation | 1. PHSP Initiatives – Primary Health Focus | 2. PHSP Initiatives – Primary Acute Work | 3. PHSP Initiatives – General Practice | 4. PHSP Initiatives – Primary Health Partners | 5. PHSP Initiatives – Workforce Sustainability |
|-----------------------|---|---|---|---|--|---|
| <i>Governing Body</i> | Office of the Deputy Secretary | Primary Health Executive Group | Primary and Acute Working Group | GP MoU Monitoring Group | Community Health Service Executive | Partners in Health ²¹ |
| <i>Coordinator</i> | Project Manager, Community Health | Director, Primary Health | Director, Primary Health | Director, Primary Health | Deputy Secretary, Community Health | Deputy Secretary Community Health |

Figure 17 Overview of Program Work streams and Governance (DHHS, 2007e)

The coordination, leadership and governance arrangements for implementation were deliberately developed to use the arrangements that already existed within services in order to enable the processes of communication of change through the relationships of work colleagues who already had understanding and trust. In addition to this, specific areas of the primary and community health services structure were deliberately enhanced with new programs and staff in line with the aims and objectives of the plan, augmenting them in some cases to better meet targets or manage changing practices for the tiered services model. For example, the 4.5 full time equivalent health promotion positions would be increased to a total of at least 7 full time equivalent positions. These positions were to be aligned locally with the primary health coordinator positions to support the networks and collaboration between professionals, community members and sectors.

²¹ Partners in Health was a formal partnership between UTAS Faculty of Health and DHHS, established in 2001 to develop undergraduate and postgraduate curricula that would improve health outcomes over time.

There were planned interdependencies, with funding to be released for a new program or service development once another project or change program had been completed. For example, the PHSP Implementation Plan made the case to increase the provision of inpatient beds and medical support on the East coast of Tasmania where there was an increase in the older population and an identifiable increased service need. Funding would be achieved through savings from converting facilities on the West Coast and in the Central Highlands regions of the State where the populations were in decline. These facilities were to become Tier 1 community health centres instead of the unsustainable combination of inpatient and aged care services that they were providing (DHHS, 2007h).

Project funding was to be used for the first two years to establish the conceptual thinking, service models, and governance arrangements. It included time for working closely with the new primary health coordinators and health promotion officer positions to realise the partnerships in primary health at the local and community level, and establish needs assessments. The tiered service model was to be mostly driven through the new structure of Primary Health Services, with the fourth tier, the development of Integrated Care Centres (ICCs), governed under the work stream for the primary and acute interface. The ICCs were a new service model and were led by the key actor group for the PHSP implementation because of the linkages to national policy and funding, and to the Clinical Services Plan. The development of the Integrated Care Centres model included funding for consultancies to establish new service structures and change management processes as well as the capital funding to develop four new buildings in the North and South of the State.

In the early stages of implementation there was a significant amount of time taken up with clarifying the overall coordination and leadership functions for the Deputy Secretary Community Health, the ComET (CPRH Executive group), the PHSP coordination group and the sub organisation leadership groups such as the Primary Health and Population Health Services Executive groups. This had not been anticipated and is likely to be indicative of the former institutional arrangements where there had been less involvement by the ComET level leadership with the service and program level decision making. However, with the levels of service change that were required with the implementation of the PHSP, there had to be a change of reporting and engagement internally. There were a variety of internal conflicts and differences of opinion about meaning and construct. For example, there was an identifiable gap between the conceptual design of the ICC model by the PHSP leadership group supporting the Deputy Secretary, and the leadership group supporting the Director of Primary Health Services that would be responsible for its implementation.

This impacted in a number of ways, but most notably there was a difference in terms of priority for the Director of Primary Health Services and her staff who were managing service provision at the same time as establishing a new management structure. There were existing challenges with the fragility of running 24-hour inpatient hospitals in some of the rural communities where there were too few local staff, including general practitioners, and a disproportionate employment of agency and locum staff required to maintain services.

There was an escalating level of conflict and tension within the immediately impacted communities of change in the central and north-west regions of Tasmania (Harpur, 2008).

The Primary Health Services management group developed a list of nine sites that would be the 'hub' for partnerships within their locality, and drafted the outline of expectation for the role and function of the approach to be taken within each area. The intention was to focus on wellness and health promotion, and to enable people with existing health and social care needs to access appropriate care, as well as develop greater self-management skills and resources. The initial objectives and strategy tasks were identified as follows:

Objectives:

- Develop an agreed definition of the Primary Health Approach
- Promote understanding of the Primary Health Approach within Primary Health
- Develop organisational capacity to implement the Primary Health Approach with a particular focus on community health centres
- Target one site in each Primary Health region for further development

Outputs:

- Project plan and documentation
- Definition of Primary Health Approach
- Additional Health Promotion Coordinators recruited
- Health Promotion Framework
- Primary Health Approach Communication Package
- Training and Development Program
- Pilot Site Implementation Plan (DHHS, 2007, 2008, 2009)

What was underestimated was the extent to which there would be barriers to changing the custom and practice of the working patterns within local centres, and particularly within professional groups such as nursing. Examples identified by McDonald (McDonald, 2004) included viable alternatives to hospitalisation with the collaboration between primary and specialised services. However, nurses in the rural centres in Tasmania were not only older (DHHS, 2006e), but had also become used to providing subacute care of in patients on a regular and rostered basis. What had seemed to be a relatively straightforward development – identifying and implementing new health promoting programs and practices at the outset – required a much more detailed program of staff support and development once implementation commenced. Despite the level of engagement that had occurred during the developmental phase of the PHSP, implementation of the changes proved altogether more complicated, with local staff finding that they were generally supported in

their resistance to the changes by local community members, whose concern was more likely focused on the broader issues of population drift. Local resistance to service changes was compounded by industrial challenges at the primary sites that were initially identified for new service models. Support for the Health Minister began to be undermined by two of her colleagues, the Hon. David Llewellyn and the Hon. Michael Polley, who were listening to the discontent of their constituents in the rural communities (Tasmania Parliament, 2009).

A further impact in shaping Tasmanian health policy is the State's legal-political arrangements, with proportional representation effective under the Hare-Clark electoral system. Five multi-member electorates are the basis for filling a bicameral state parliament. The practical result of this arrangement is that candidates within each of the major parties (Australian Labor Party, the Liberal Party and, more recently, the Tasmanian Greens) are in competition with each other, as well as with representatives from opposing parties. So, despite Members Llewellyn and Polley being members of the Labor party who were in power in the state, the impact of this competition was that parliamentarians tended to be more responsive to the wishes of their electorate than to a uniform party policy position. Tasmanian politics have been described as the 'politics of place', (Crowley, 2000) with regional differences of the greatest significance to the political landscape, and party-political differences taking second place.

There was slow progress with the initial projects and initiatives that had been identified and by the time the first public report on progress of the THP was published in December 2008, they had reduced from an initial list of seven:

- Primary Health Development
- Planning for Sustainability
- Consistent Community Health
- Safe, Quality Services
- Rural Health Centre Redevelopment
- Preventing and Managing Chronic Disease
- Primary Health Partnerships
(DHHS, 2007e)

To a total of four projects as follows:

- Primary Health Development
- Planning for Sustainability
- Consistent Community Health

- Rural Health Centre Redevelopment (DHHS, 2008g)

Time and effort was necessarily focused on the communication and training of staff to implement the primary health approach, however this had to run alongside the redevelopment of rural health services to the new tiered service delivery model. Further structured planning for the primary health partnerships was deferred and the links between services, including citizens and the community sector, were rolled into the consumer and community engagement project.

At the same time there were multiple changes to the structure and organisation of the central DHHS as well as at the national level within the Department of Health and Ageing. In December 2007, a new Secretary of DHHS commenced just weeks after the national election that appointed a Labor Government under Prime Minister Kevin Rudd. Only a few months previously the Mersey Hospital in the North West of Tasmania had been 'rescued' and purchased for a dollar by the previous Liberal-National Coalition Australian Government days before the national election. This had occurred because of the combination of a marginal national electorate in the North- West of Tasmania, together with community concern that the proposed service model changes would reduce the surgical capacity of the hospital. This had been one of the specific recommendations in the Richardson report (2004), and had been widely promoted as a national perspective on the case for change. At the local level there was a lot of confusion, and the THP coordination group had to immediately start negotiations with a new national government to consider the implications of the arrangements. This was an event for which there was no precedent, and the communities around the smaller rural in-patient facilities in the North West and Central Highlands took the opportunity to lobby nationally to prevent service change in their towns.

Minister Giddings had responded to criticism in Parliament just a month ahead of the national election, on 30 October 2007, (Tasmania Parliament, 2007) with the following:

It seems to me that we have forgotten the driving forces behind the Tasmania Health Plan. [...] the reality is that this Government has been all about improving health services on the west coast ... What you have to do is go back to the reality of why we made those decisions in terms of the Tasmanian Health Plan. We had issues with Rosebery where we found it very difficult to get nursing staff. We were flying nursing staff in regularly from South Australia to prop up those services. What were the services we were propping up? Inpatient beds that are not acute beds, they are rural health beds, subacute beds. We were propping up beds that people were not using. There was very low utilisation of those beds. Meanwhile Ms Putt [Leader of the Greens Party of Tasmania] talked to me today in question time about having to support smoking cessation programs and the like. You are quite right, Ms Putt, we need to invest in programs such as smoking cessation, not in expensive beds that nobody is even using.

You are standing here today and saying that the Government is wrong to remove funds from beds that people are not using to put into the services they do need. It is not about cutting funds from the west coast at all, it is about making sure we are investing in the services that community require that they are not currently getting, so that we can deal with their chronic diseases and provide them with better home and community care services.

The Secretary, who officially took up the position in DHHS in December 2007, praised the DHHS executive and the Tasmanian Government, particularly the Minister for Health, for an ambitious and forward thinking health plan. At his first meeting as Chair of the Tasmania Health Plan Coordination Group on 7 December 2007, the Secretary was briefed with a Background Paper that described the governance structure that had been established (see Appendix 1), and the key projects and challenges with the implementation of the Clinical Services and Primary Health Services plans to date, including the Mersey hospital in the North West. Restructure was immediately required as a result, and the whole of the health plan was to be brought together. The Secretary asked for the implementation of regular and consistent progress reporting at every level from the project level up-wards, and for the integration of the whole of the Tasmania Health Plan into one implementation structure.

The first of the THP Community Forums were held in March 2008, and they were established to communicate progress on the THP Implementation. On October 2007, approval had been given by the Government to establish Area Implementation Forums to be held twice a year in each of the North, North West and South of Tasmania. In his first address, the Secretary described a shift in the relationship between the 'head office' of DHHS and its service delivery arms of acute, primary and community health services as follows:

The new DHHS will focus primarily on building a care delivery system – the 'Department' as it has been known will make up only two per cent of budget allocation and will be strongly focused on supporting the operational units/ NGO's to deliver services to the community (making up the other 98 per cent of budget allocation).

The three key elements of the care delivery system will be:

- The Department – small and concerned with policy, strategy, performance and governance
- Operational Units – significant in size and focused on delivering to the client
- The Non-Government sector – large and growing and a vital part of care delivery.

It is a new way of thinking about how we work, a new culture and a new approach to building working relationships. (DHHS, 2008i)

Through this 'new relationship', the consideration of a commissioning model for service delivery for Tasmania was being flagged, although it was some time before this concept was developed further. The implementation of the PHSP was renamed the Primary Health Approach within the Tasmania Health Plan Implementation and the next two significant changes that followed were to appoint the Deputy Secretary CPRH as the overall manager of the implementation of the THP and to announce that Primary Health Services would be 'folded in' to a new Area Health Services model that would bring health services into their respective regional areas in the north, north west and south of the state, under a single CEO for each. The Deputy Secretary CPRH was renamed Deputy Secretary for Community Health Services and then subsequently Deputy Secretary System Development. Further changes were then announced to all of the structures beneath that in order to meet the new approaches to managing and reporting required by the DHHS Secretary.

The author of this thesis had been appointed as Director Community Health Services in November 2007 and then, through several position requirements and changes that included having responsibilities added and then taken away again, became the Director of Statewide System Development by May 2008. A further and more significant implementation challenge during this time was as a result of the transfer of the Mersey Hospital to the Australian Government. This proved to be particularly complicated as there was no established precedent for the Australian Government to provide services directly. In addition to the intergovernmental relationships that were actively engaged to find a workable solution, a consultant was employed to revise the Clinical Services part of the THP to take account of the implications of this significant change.

In the meantime, the proposed changes in the Central Highlands region of Tasmania had been described as, for example:

[..] Hospital is currently having extreme difficulties in retaining enough nursing and care staff to provide a 24-hour, seven day a week service. It is also not reasonable to expect a single GP to be on call 24 hours a day, seven days a week.

The facility therefore will move from a Tier 2 inpatient and residential aged care facility to a Tier 1 Community Health Centre. This will be based on a more flexible model of care with a combination of planned respite beds, a day centre and nursing and personal care in the home that will enable older people to remain in their community.

It will also provide nursing clinics, more allied health services, outpatient services and general practice from the Community Health Centre.

Individualised care arrangements will enable older people to receive care at home, specifically targeted at their care needs, whether it is meals, domestic assistance, nursing or personal care.

Clients requiring hospital admission will be assessed according to set criteria and referred to another appropriate facility. Overnight planned respite will be available as required for non-health related conditions (ageing and social support situations).

There will be a much greater focus on better prevention and management of chronic diseases, using a team approach across community organisations, general practice and other primary health services. (DHHS, 2007g)

The now Deputy Secretary for State-wide System Development reported on progress to the THP Community Forum in July 2008 (DHHS, 2008f) with the following:

Of course, Tasmania's Health Plan included significant changes for the Mersey campus of the North West Regional Hospital ... but that's as far as we got before the previous Australian Government took ownership of the Mersey last November. We are awaiting advice from the new Australian Government about its plans for services to operate out of the Mersey into the future.

[...] changes were also brought about at in the North West and the Central Highlands, which we all know has received significant media coverage. The reality on the ground was a high level of commitment amongst staff during a difficult time. The North West in-patient rural facility has changed. On 28 September 2007, the Community Hospital became a Community Health Centre, offering extended hours of operation and a wide range of primary health care services.

In the Central Highlands, the rural in-patient and aged care facility was found to be unsustainable due to workforce shortages, low use of the inpatient beds, and the very high cost of aged care beds. Changes that have been introduced are aimed at improving services for the whole community and focus on primary and preventative health.

However, continuing concern in the Central Highlands about the future of health services have prompted an independent review of the feasibility of a multi-purpose health service in the Central Highlands, as proposed by the local community. Terms of reference have been agreed and expressions of interest for a consultant will be advertised shortly.

There is a 'carefulness' to the language used by the Deputy Secretary, which is reflective of the rifts and differences that were, by now, beginning to open up on a regular basis between the different actors and institutions internally to DHHS, as well as with stakeholder relations with local government, professional organisations and the Divisions of General

Practice. However, there were some positive highlights and endorsements that came from staff internally and from members of the general public.

For example, this photo follows a presentation by a consumer presenter to the THP Community Forums and brought this collection of shoes to represent the many types of people that the Tasmania Health Plan seeks to benefit.



Figure 18 Photo image included in the THP Consumer Forum Report for October 2008

By the time the Progress Report for December 2008 was published, (DHHS, 2008g) several projects were reported as having been “established as part of the ongoing work of DHHS”. In part, this was because the governance challenges were becoming too hard with the multiple changes in organisational structures, and the articulation of the Department as separate from the ‘service delivery’ or ‘operational’ area health services.

The intention was to both manage the process of implementation within the constraints of a limited budget, as well as to optimise the use of existing governance structures so as to ‘normalise’ the implementation process within existing work areas. The DHHS Secretary, with experience of the great sophistication of policy and authority of the polity in the NHS, may have held a greater belief in the readiness for new methods of management than was actually feasible to implement, at least at the same speed, in Tasmania. While it is likely that a fundamental change is required to establish a stronger focus on primary health in Tasmania, this has also not been achieved nationally, despite efforts dating back to the final report of the Better Health Initiative in 1987 (Boxall & Gillespie, 2013, p179-180).

The initial model for the Primary Health Partnerships was as follows (Harpur, 2007)

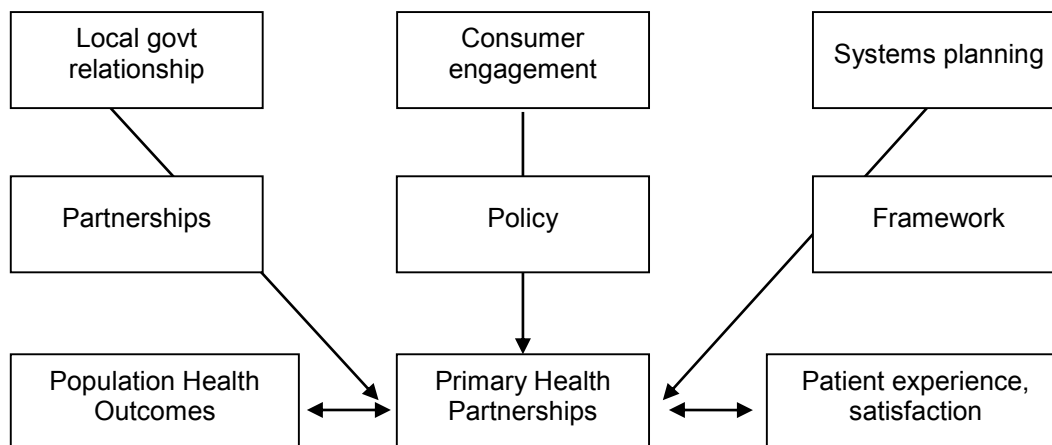


Figure 19 Model for Primary Health Partnerships

This model for the proposed Primary Health Partnerships project articulated the goals of integration horizontally and service networking. The partnerships were intended to be used on a hub and spoke model basis, pivotally placed to enable the opportunities for improving communication and service planning and development by drawing on local level information and experience.

While the initial intention was to put these elements into place in Tasmania, in reality, implementation was hampered by the cumulative impact of organisational changes that impacted on the visibility of leadership, which, in turn, exacerbated the tensions experienced by the central bureaucracy with the local community level services. As the gaps between different parts of the organisations began to widen, the Primary Health Services management group in particular was struggling to manage services and changes being imposed from above as well as being expressed from within. At the same time as the new Area Health Services were established, that incorporated the Primary Health Services structure, the Area CEOs were at liberty to consider changes to their respective structures. Consequently, during 2009, the Primary Health Services regional structures, that had been a feature of the arrangements for implementing the primary health approaches through the coordinator and health promotion positions, were dismantled in the North West and South of the State. The Northern region was the only place that appointed primary health coordinators that were concomitant to the implementation plan. However, they were isolated without a network of similar positions across the State and lasted less than 2 years before being dismantled in 2011-2012.

What is observable is that the primary and acute health sector networks tended to interact intensively because of their relationships in terms of service delivery. They were also managing the potential integration of state-wide mental health, alcohol and drug services and palliative care, as well as the changes in arrangements for primary health care and the Divisions of General Practice. For example, in terms of the implementation of primary health networks there were strong networks that were already established and working in

the North and South of Tasmania. These existing networks, as examples, included local government staff and sometimes representatives, the local general practitioners or practice managers, visiting allied health professionals, community sector organisations, and other service providers such as the Child Health Nurses. Each of these staff and community workers have a stake in health improvement and some of them will have greater capacity and capability than others to participate in and influence the policy processes to establish new relationships, models of service, and programs. These networks picked up and worked with the Health Promotion and Self-Management Frameworks, for example, and considered and critiqued the relevance and value to them locally, leading to the more recent establishment of a training program that was provided twice a year in each of the North, North West and Southern regions. However, there was no success in the establishment of the proposed new primary health partnerships during the active implementation phase of the Tasmania Health Plan.

There were fewer problems in the institutional relationships within DHHS where there was greater clarity of the mutual interests, although those interests varied and were not always predictable with different policy decisions and directions. These included the relationships between population health and mental health policy division, or the ambulance Tasmania service and the alcohol and drugs policy services.

The Secretary of DHHS continued to implement more organisational changes first to establish the Area Health Services and to incorporate the State managed primary health services, and then the DHHS Executive leadership structure was changed again, this time to a new “matrix management” approach. This further complicated communication between the various health institutions of government and the community and slowed the progress of implementation. The significant range and types of changes, signalled in the presentation to the THP Community Forums a year earlier, included that of ‘operational’ services being described as ‘below the line’. The Deputy Secretaries were all now tasked with a relational role that was no longer directly accountable for, or managing, hospitals or health and community services and described as an ‘above the line’ accountability. The Secretary stated:

I strongly believe that 2009 will see us – and the patients and clients we serve – reaping the benefits of a new way of working.

The major theme of the structural changes is integration – so that we avoid overlaps and can close off gaps in service provision, and improve communication between service providers and our patients. A revised organisational structure has been developed to help staff to understand the important links and focus for our work in coming years.

You will see that DHHS functions have been reorganised under eight cross-agency Groups:

- Human Services
- Strategy, Planning and Performance
- State-wide System Development
- Chief Health Officer
- Chief Nurse and Allied Health
- Care Reform
- Finance and Business Performance
- Office of the Secretary

[...] the CEOs of hospitals, the ambulance service and primary health services no longer sit under a single Deputy Secretary. These CEOs are responsible for the day-to-day management of their services, and are accountable for delivering services against Departmental policies, plans and standards – all with their own Resource and Performance Agreement. They now report to the Secretary but will work directly with the relevant DHHS Executive team member for various elements of their operations (e.g. to the Chief Financial Officer on budget issues and the Deputy Secretary, Care Reform on safety and quality issues). (DHHS, 2008d)

This substantive and further organisational change drew further concerns and distancing from service provider institutions regionally and at the local level from the THP implementation process. In this environment of significant change it was challenging to focus on the potentially new, though important, opportunities for a primary health focus with local partners and collaborators.

The capacity to deliver the implementation projects and initiatives associated with each of the work streams varied with the existing and sometimes competing priorities of the governance bodies and the respective leader responsible. For example, the Director of Primary Health was initially responsible for the Primary Health focus projects to be implemented through the Primary Health Services management group, but this had more or less broken down because of the pressures from local services. The subsequent proposal to restructure Primary Health into the new Area Health Services by 2009 left no capacity for driving the primary health leadership of the implementation, and the former management group was dismantled. In contrast to this, the Workforce Sustainability stream that was governed by Partners in Health was criticised by professional organisations and the Trade Unions, particularly the ANF and the AMA, for a lack of engagement and communication. However, the establishment, development and implementation of the projects within this stream were successfully completed and relatively manageable. This is likely to be because there was less of a communicative discourse, and the number of different institutions and actors was moderately limited to a management group who already knew each other, had some history of partnership and collaboration, and were focused with tasks that had a

context of a single policy initiative. The same was moderately observable in the case for the General Practice workstream, although there were tensions to manage and negotiate between the boundaries of state and national government responsibilities with changes in national reform priorities that had implications locally.

5.3 Engagement between actors and institutions

The network governance, or 'matrix management' model that had been introduced by the DHHS Secretary in 2009, posed significant challenges to communication within the DHHS and between the THP Leadership group and other internal management groups and organisations. The new management model was not widely understood by senior executives and leaders, or their staff. The impact of these changes on top of the establishment of new models for service delivery and concepts of collaboration and partnership provides explanation of the complexity of the interaction processes and their outcomes. The strategies that were required to meet expectations, in order to achieve results, were probably not widely understood or implemented.

Increasingly integrated approaches to policy development and service delivery depend on collaboration within and between sectors, as well as with communities and the public. With the need for collaboration there may be talk of 'joined-up' government and partnership, but there is little evidence of 'seamless care' for patients. Implementation of reform, nationally as well as locally, has shown little evidence of breaking down the silos of different care providers and sectors. The PHSP Implementation Plan was purposefully intended to use networks and partnerships that place reliance on trust. However, the strategies of engagement and reciprocity were at odds with the organisational structures at regional and State level. Fundamentally this put them at odds with the professional norms, in particular for nursing and other health professionals that are hierarchical, discrete and compartmentalised (Bell, 2004).

The staff and their local stakeholders in rural in-patient facilities, multi-purpose services and centres resisted change despite the good intentions and the efforts of many individuals and the PHSP key actor groups in particular. The institutional environment for implementing more 'joined-up' approaches to service provision is generally likely to resist and undermine approaches that challenge the structures and norms. However, this was made even harder because of the constant changes in the structures of the organisations of the Department at the State level that coincided with significant policy changes happening nationally.

It is a feature of the responsibility of the Secretary of any State Department, or Agency that they are also responsible, to support their Minister in intergovernmental relations nationally. This had been challenging with the takeover of the Mersey Hospital in the North West of Tasmania, but improved with a close alliance between the Tasmania Minister for Health and her national counterpart, the Minister for Health Nicola Roxon.

There were three significant and relevant health policy reforms nationally that impacted on the implementation of the THP relevant to this case study.

The first was the establishment of a national Primary Health Care Strategy, announced in early 2008 with a discussion paper that proposed ten elements to underpin a future primary health care system. This included: patient centred, focused on preventive care, and flexible to respond to local community needs and circumstances through sustainable operational models. Tasmania's Health Plan and the Primary Health Services component, including the introduction of a tiered service delivery model, was seen by the intergovernmental policy leadership and the Minister for Health as a strong base for supporting a national plan for primary health care.

On 16 February 2009, the National Health and Hospital Reform Commission released its interim report, "A Healthier Future for All Australians". It invited individual and collective action to build good health and wellbeing, and established ten-year goals for health promotion and prevention, together with a defined funding source for these activities.

The third national strategy was the Preventive Health Strategy launched by the then national Minister for Health, the Hon. Nicola Roxon, on 9 September 2009. The goal was "making Australia the healthiest country by 2020" and included strategies to tackle the causes of chronic diseases by reducing obesity, smoking and the risky and excessive consumption of alcohol.

The implications for Tasmania were that many of the reform directions under the implementation of Tasmania's Health Plan were in line with the national reform agenda. Partnership directions nationally for subacute care, activity based funding, workforce and training, for example, aligned with the THP directions for a tiered service model, increased emphasis on prevention, and improved service integration.

However, a closer consideration of the national reforms suggested that it was not likely to positively support the further implementation of primary health approaches. The reforms were premised on the establishment of several new national authorities which could result in a number of new and independent health bureaucracies competing for health funding. The reforms called for an increased role for the primary care sector at a time when the supply of GPs, especially in rural and regional areas, was decreasing. The DHHS Secretary was engaged and active at the national level, and increasingly invited a consideration of the UK approaches to reform be considered, including the invitation of UK experts to provide consultancy and advice to the local developments. This received a mixed response and was criticised in the media and in Parliament as the following extract from Hansard for 29 October 2009 (Tasmania Parliament, 2009) illustrates:

My question [Honourable Brett Whitely, Opposition member for Health] is to the Minister for Health. Minister, you continue to refuse to answer legitimate questions about the total cost to taxpayers of visits to the State by Dame Catherine Elcoat from

the UK to provide advice on a number of things including nursing, so I will try it again, Minister. What has the total cost been to taxpayers in airfares, accommodation and all other expenses of Dame Catherine's various trips to Tasmania? It is a fact that the department has not acted upon any of the recommendations Dame Catherine made in a report arising from these trips? If you cannot answer these questions, Minister, doesn't it just prove that you are trying to cover up a pattern of extravagance and waste within your own department?

Ms Giddings: Thank you, Mr Speaker. He [Mr Whitely] does not like the fact that there is more to a story that needs to be told than he would like. Dame Catherine Elcoat did visit us. The department has previously confirmed that she visited Tasmania five times between 19 April 2008 and 13 March 2009, 19–25 April 2008, 19–20 June 2008, 29 September–3 October 2008, 26–28 November 2008, and 7–13 March 2009. The department paid for Dame Catherine's airfares, accommodation and meals on her visits. However, Professor Elcoat charged no consultation fees and none were paid.

She travelled business class at a cost of some \$40,000 for the five return trips. The value of the work she has done for us would be in excess of some \$80,000, for which she has not charged us one cent. In fact I think the Opposition should be writing to Dame Catherine and thanking her personally for the contribution she has been making to the Tasmanian health system.

The Minister for Health consistently supported the action of her delegate, the DHHS Secretary, throughout his term of office.

In terms of the internal engagement and relationships within the DHHS actors, there was, at least in the initial phase of implementation, recognition of the need to commit time and effort to maintaining and developing professional relationships and understanding. Policy implementation is an increasingly complex task in which there is a high level of sophistication required in the careful management and coordination of the processes. The ideas had been relatively well communicated in the coordinative sphere, though probably less sustainably managed in the communicative sphere. Network management and collaboration between the various actors and institutions took time and effort and was a substantive feature of the workload by the small group leading the implementation of the THP.

There are significant challenges for governments when developing the agenda for communities to participate in the development of health services policy. Further complexities in terms of the application of participatory techniques can be found between the various health organisations themselves. Health service operational and business units are constructs of government to meet their own needs for organising their business. As such the instruments for participation are likely to be the same, despite the differences of appropriateness and capacity to apply them between the acute, primary and community

services. Whilst the acute and aged care sectors provide, arguably, the greatest volume of participation attempts, the primary health and community health sector is where the instruments applied are more likely to be at higher levels on the 'ladder of participation' (Arnstein, 1969). The nature of primary and community health care is that it is characterised by a diverse range of consumers and providers, with the providers themselves working across a continuum of care, depending on the needs presented locally. On this basis, along with a, albeit patchy, history of applied health promotion and community development policies, there would have been a significant opportunity to explore participation with this sector, in both its services and policy direction.

There was, however significant confusion during the development of the Integrated Care Centres that overlaid the confusion of organisational change and was compounded by the national health reform agenda that included funding for a program of GP Super Clinics (Department of Health and Ageing Australia [DoHA], 2008) that would:

GP Super Clinics will bring together general practitioners, practice nurses, visiting medical specialists and allied health professionals and other health care providers to deliver better primary health care, tailored to the needs and priorities of the local community.

GP Super Clinics will support primary health care providers to adopt models of care focused on best practice integrated multidisciplinary team-based approaches and efficient and effective use of technology. GP Super Clinics will provide a greater focus on chronic disease prevention and management, as well as economies of scale in delivering high quality health care.

While it is likely that GP Super Clinics will take pressure off local public hospitals, all patients will retain their right, under the Australian Health Care Agreements, to attend public hospitals and emergency departments at no cost if they so wish. Services provided at GP Super Clinics will be provided under the usual fee for service arrangements. (DoHA, 2008, p5&6)

The THP implementation leadership group had made some small progress with the engagement of different sectors through regular meetings, site visits and the program of structured THP Consumer Forums. However, this was undermined when the Australian Government advertised regional public consultation for the proposed policy development of the GP Super Clinics without any reference or engagement with the DHHS, let alone their own Department of Health and Ageing (DoHA) State office.

Local consultation is an important component in the implementation of the GP Super Clinics initiative. As part of local consultation, the Australian Government intends to conduct a formal public meeting in each GP Super Clinic locality.

[...] while the formal public meeting is a key step in the consultation process, this meeting will not be the only mechanism by which the Department will seek local input. ... Details of this event, including invitation details, will be advertised locally, as well as on the GP Super Clinics website. It is also intended that a summary of the outcomes will be provided on the GP Super Clinics website after each meeting. (DoHA, 2008,p8)

Community participation in health services delivery has been demonstrably revealed to be a complex policy arena. The scope of arrangements, together with the range of people who can be involved as individuals, clients and community interest groups, adds to the complexity. It is important to acknowledge that the diversity of structures for delivery of health services, together with the range of influences and the power of individuals and communities, will either enable or disenfranchise their capacity to engage. In the first instance, the THP Coordination Group had to align the Integrated Care Centre Tier 4 model to accommodate the GP Super Clinic proposals, and the proposal for one of these centres reads as follows:

Traditionally, settings for the delivery of health care have been determined largely by their sources of funding. State-funded health services have been provided mainly through State-owned facilities which often have been established in relative isolation from Australian Government or privately-funded health care providers such as GPs, private hospitals, private community nursing services and private allied health services.

Tasmania's Health Plan recommended the establishment of Integrated Care Centres (ICCs) in major population centres across Tasmania (including the Clarence municipality) which would:

- accommodate a range of health services that provide efficient, integrated care regardless of who funds, owns or provides each element of the services
- operate under a philosophy which is less interventional and oriented towards care in the community rather than institutional care
- provide greater certainty of access for clients because they focus on non-emergency services, including a broad range of non-admitted primary, secondary and tertiary services, short-stay elective services and specialised subacute services.

The ICC objectives are to:

- provide an integrated model of care
- with focus on chronic disease

- divert patients from an acute care destination/facility to a more appropriate setting of care in order to improve the patient's experience and outcome of care.

This model is closely aligned to the objectives of the GP Super Clinic as initiated by the Federal Department of Health and Ageing and supported by an inter-jurisdictional group working to develop the national approach. (DHHS, 2008a, p4)

Despite the confusion with the GP Super Clinic program, there was a strong interest and support for the development of the ICC model by individual citizens. They understood and proactively encouraged the opportunity to have a single point of referral to specialist services. They also wanted to see the provision of renal dialysis and diabetes care away from the hospital and closer to where patients and their families lived. However, it is fair to say that it was a more complex proposition for the variety of health professionals and organisations involved and many of them were less keen, as the following extract of a letter from the Secretary of the DHHS to the ANF in response to questions about staffing implications reveals:

Given the scale of the development, a range of communication measures have been put in place to keep staff up to date with developments, including a regular Project Fact Sheet, updates from the Project Manager at significant milestones and on request, and regular CCHC [Clarence Community Health Centre] staff meetings with progress reported by the Centre Manager, Primary Health Services.

In recognition of the need to keep staff informed, Primary Health Services have established the Joint Unions/Management Industrial Committee (JUMIC) – Clarence Sub-Committee for the purpose of identifying and addressing industrial issues which may emerge during the transition from CHC [Community Health Centre] to ICC [Integrated Care Centre] and GPSC [GP Super Clinic].

As the collaboration with the Australian Government was confirmed, the State Health Minister made the announcement within the parliament as follows:

As members will be aware, the Clarence Community Health Centre is a central part of government health services on the Eastern Shore and today I am delighted to announce that the site will be developed as an Integrated Care Centre with the provision of some \$13m of funds from the state and \$5m from the Australian Government.

Under this plan the new ICC will see a GP Super Clinic, an Integrated Care Service focusing on complex and chronic disease, as well as other community-based health services provided by both the government and non-government sectors.

It is important to note that these services will need to be confirmed during the planning process, but I think you can understand why we are excited by the possibilities of the new Integrated Care Centre.

[...] But again, let me repeat that the provision of general practice and other primary care services will continue. The Super Clinic will be developed in partnership with the state utilising the GP practice at Clarence as the core practice. And no, we are not using state funds to subsidise the GP Super Clinic. We are cooperating with our federal colleagues to develop an integrated care precinct that will provide great economies of scale in terms of buildings and a significantly improved range of services for the Eastern Shore.

It is also important to note, that despite what members of the Federal Opposition may claim, a separate \$2.5m will be available for a Super Clinic at Sorell, which will be a separate exercise.

At Clarence, we believe by working with the Commonwealth we will be able to do so much more, such as providing a greater focus on chronic disease prevention and management. We will be able to focus on wellness, through maintaining people in a healthy state, preventing relapses and reducing the need for admission to hospital. This will reduce pressure on valuable public hospital beds as well as ensuring that residents on the Eastern Shore have better health outcomes.

So as you can understand, we are quite excited by the move because we believe it will not only provide better services to the growing community on the Eastern Shore, but also act as a model for others to follow. (Tasmania Parliament, 2008)

The following principles were identified as fundamental to the practice and development of integrated care. They were identified in the conceptual development of the integrated care thinking toward the Tier 4 Integrated Care Centres, and with reference to the ways that services would be developed in each of the services and facilities across the tiered services model. This was detailed in the Integrated Care Policy (DHHS, 2008I), which involved health and human services professionals in its development (see Figure 20).

| Principle | Description | Example strategy |
|---|--|--|
| Person- or patient-centred approach | A collaborative and respectful partnership exists between the patient and the service provider | Patients or clients and their carers or family members are central in decision-making about pathways and options |
| A wellness and health independence orientation | There is an expectation of optimising independence, and patients are encouraged to build ownership of their own health. | Health promotion and self-management principles underpin the way we work. Staff use motivational interviewing techniques as standard. |
| Respect for different roles and capabilities of health care professionals and consumers | Service providers and patients listen to each other without judgement. | Service access is determined by clinical need, and takes account of the preferences of patients and their carers |
| Coordination and integration of service planning | Patients experience a seamless transfer of care between different providers and settings | Service providers have a “pull to” attitude to referrals more than a “push from” |
| Collaboration between researchers, educators, students and service providers | There is a commitment to create an environment that encourages learning and values discovery about the factors that contribute to improvement in individual and community health and wellbeing | There is an active program of breakfast and ‘lunchbox’ learning, as well as more formal research and professional education and development |
| Quality evidence-based and timely services | Patients receive services that meet quality standards, based on the most contemporary informed evidence and delivered in a timely manner | Communities of practice are common, and the centre is accredited by a common quality standards system |

Figure 20 Features of the DHHS Integrated Care Policy

The service model for the Launceston Integrated Care Centre was similar to that of Clarence in the initial development. It was intended to support people:

- who have complex health care needs who will benefit from coordinated care and service integration provided by multidisciplinary care teams
- for whom evidence-based care suggests that more than a single provider would be beneficial
- for whom there may be opportunity for education and fostering of self-management
- at risk of hospitalisation such that existing service arrangements may not mitigate

- where one stop service availability provides access advantages
- from particular population groups that may benefit from this service (DHHS, 2009a).

There was a collaborative and positive engagement with the early conceptual discussions about the options and purpose of a new model of service delivery, and the resulting model proposed a way forward that met the interests and needs of clinicians and patients alike. However, the resistance to changing practice for professional groups and clinicians became evident once the service planning began in earnest. Somewhat similarly to the experience of implementation in the south of the state, in the first service model summary for the Launceston ICC different views were strongly expressed. For example, the hospital medical staff thought that they should be the only source of referral to the ICC, but some of the health professional leaders, managers and the Northern Division of General Practice thought that they too should be able to make referrals. However, this was not explicitly raised at Steering Committee meetings and continued as a point of contestability that was still unresolved once the centre opened in 2010.

A significant observation with regard to the engagement between individuals with the implementation of the tiered service delivery model is that the most productive relationships were entirely driven by individuals with deeply held commitment to the values and the philosophy of change that they were intentionally progressing. There were many conflicting factors impacting on implementation. The policy entrepreneurs (Kingdon 2003) who formed the THP leadership group were also akin to the advocacy coalition of Sabatier's framework (Sabatier 1993), with technical information and knowledge about the policy change they were establishing. They were skilled at 'coupling' their ideas to the problems and at integrating policy communities with the broader events of the health policy impacts of chronic diseases.

5.4 Impact on health outcomes – perceived and real

The THP Implementation Plan focused on the action required for the short to medium term of one to three years. The plan assumed a 'rolling wave' approach to implementation that acknowledged many changes taking place at the same time and without all details known in advance. The approach took account of the detailed implementation being developed as the "horizon" approached and the work that was required became more evident.

This required a sophisticated approach to the co-creation of initiatives within a model of network governance, and was a feature of the implementation planning approach that the PHSP leadership group were already familiar with. However, when the same language was used in restructuring DHHS with a matrix approach, the combination was not only overly ambitious, but also more sophisticated than the complexity of the operating environment and communications within and across the multiple actors, interests and institutions allowed for.

The first restructure was announced in March 2008 as a joint statement by the Minister Lara Giddings and Secretary David Roberts:

Ms Giddings said the changes were recommended by new Department head David Roberts after two months of meetings and discussions with staff and stakeholders across the State.

‘This is about improving services for our patients and clients – the thousands of people who use our hospitals, health centres, group homes, affordable housing, and services in the home every day,’ Ms Giddings said.

‘The major reforms introduced by Tasmania’s Health Plan will now be more closely reflected in the Department’s structure.’ⁱ

This first restructure included the alignment of the whole of the management of the THP under a new Statewide Systems Development team who would focus on “integration, partnership and engagement”.

The early Implementation Plan for the PHSP began with the introduction of themes and target outcomes as follows:

| Theme | Outcome |
|--|--|
| <i>The primary health approach²²</i> | Services that promote the primary health approach, contributing over time to improved health and wellbeing outcomes in the Tasmanian community. |
| <i>Health planning principles</i> | A primary health system that better meets the changing needs of the Tasmanian community. |
| <i>Service delivery model</i> | A tiered service delivery model establishing an integrated network of primary health services will provide a sustainable service system for Tasmania. |
| <i>The prevention and management of chronic conditions</i> | Each health centre to have a role in working with key stakeholders and the local community to design and implement programs to support healthy life conditions and choices, and address the causes of illness and injury. |
| <i>General practice integration</i> | A new relationship between general practice and the Department will be established that better supports the sustainability of the sector and provides additional capacity to respond to the challenges of chronic disease. |
| <i>Rural health centres</i> | An enhanced role for rural health centres will be implemented to ensure these services better meet the needs of the Tasmanian population and their local communities. |
| <i>Communication and collaboration between service providers</i> | Improved communication and collaboration between service providers |
| <i>Community participation</i> | Strengthen community participation in primary health services. Encourage an increased sense of involvement in personal health maintenance and treatment. |

Figure 21 Primary Health Services Plan Themes and Outcomes (DHHS, 2007e)

Evaluation of potential impact and outcomes were considered at the outset. It was intended that baseline data be collected at the beginning of any new service intervention, new program or introduction of a new service model. Outputs were to be evaluated using a 'snapshot' approach of comparative data within 12 months of implementation, with a further follow-up snapshot potentially to be collected 12 months later.

Outcome measurement was recognised as more complex to measure, especially to determine the impacts relative to specific changes or interventions. The main expected method for outcomes realisation would be through a Population Health Survey, (DHHS, 2009b) which is a surveillance and monitoring survey consistent with approaches taken in other jurisdictions, and in addition to national surveys including the census.

Data availability would vary at the individual project and initiative level, and the following indicative examples were provided in order to progress discussion about the kind of data that could be collected to evaluate under each of the program logic categories.

²² The Primary Health Approach is derived from the Alma-Ata, WHO. 1978. Declaration of Alma-Ata. International Conference on Primary Health Care, September 1978 Alma-Ata, USSR. WHO, 3.

| Program logic domains | Characteristics | Sources of data |
|--|--|--|
| <i>Service characteristics</i> | Distance from other services, ²³ accessibility: | Information on transport options available (community transport, hospital patient transport, local government services) Perceptions of accessibility (sampled through interview or questionnaire) |
| | Service/facility volume/capacity: | Service utilisation data (changes in the number of people accessing services, number of occasions of service, number of hours of service). This may include an increase in activity in adjacent sites if some services are no longer offered by the new model of care (Community Health Information System) |
| | Model of care, range of services provided: | Service provision data (changes in the scope/spread of services) illustrated through comparing the previous model of care to the new model of care. This may include changes in the type of new client admissions or discharges to services (Community Health Information System) Percentage of service budget spent on particular services (for example health promotion activities) as compared to the baseline budget split – ‘money-mapping’ the investment pattern in services (DHHS finance reporting system) |
| <i>Consumer characteristics (sources)</i> | Knowledge and attitudes (system-level): | Consumer survey data indicating changed understanding of health service delivery, levels of satisfaction with health service delivery. Self-assessed health, including mental health and capacity to make decisions (health literacy) |
| | Action and experience (individual level): | Changes in the numbers of clients participating in chronic disease management programs etc (case audit) |
| | Clinical indicators: | Random clinical client record audit, consumer questionnaire. |
| | Functional indicators: | Random clinical client record audit, consumer questionnaire. |
| <i>Health and wellbeing outcomes (sources)</i> | Population expected to reflect changes over time: | Data from population health surveillance systems Annual data on mortality and hospitalisation available at Local Government Area |

Figure 22 Potential data to evaluate implementation of Primary Health Services Plan against Program Logic domains (DHHS, 2007f)²⁴

In terms of reviewing progress against intended outputs, there was a relatively successful process measurement of results. In particular, a self-assessment by the internal actors who

²³ In assessing the sustainability of services for the PHSP, distances from other services were described as: Close if it takes less than 60 minutes to drive to a major regional hospital. Accessible if it takes between 60–90 minutes to drive to a major regional hospital. At some distance if it takes between 90–180 minutes to drive to a major regional hospital. Remote if it can be only reached by air or takes more than 180 minutes to drive.

²⁴ Extract provided to Meeting of the THP Coordination Group January 2008 for endorsement

led specific projects and programs suggested that between 73 and 82 per cent of them had explicitly considered the objectives of the THP and PHSP in the development and implementation of their projects and initiatives. As a rule, however, the same survey found that staff did not believe that they had achieved the planned objectives, as these generally represented long term and significant changes which would not be seen within the given timeframes (DHHS, 2010b). Outcome measurement was not achievable within the timeframe of the THP implementation phase.

Extract from the THP Progress Report December 2008:

‘Seamless service’ is the aim of integrating acute and primary health services. As a way of working towards that goal DHHS has started a transition to organise services by geographical area. However, bringing together primary and acute health services under area management is *not* a return to the regional health boards of the past.

Tasmania’s Health Plan provides a statewide framework in which a devolved structure [the Area Health Services] such as this can operate. The new ‘area’ model for planning, developing and managing health services (i.e. a single management team in each area) will be complete by the end of 2009 and is described in the progress chart through changes in the projects IAP02 and IAP03.

The aim is to create a health system model where resources can move across the sector to best serve the needs of our communities. This will create local decision-making about where scarce resources should go and create a linked health care service with sub-regional communities. This will also cut red tape for patients.

Acute hospitals will not overshadow the primary health agenda. Although budgets across community and hospital will remain independent, services will come under one umbrella to raise the quality of care, avoid overlap in service provision, close off gaps in service provision and improve communication between service providers and patients/clients. (DHHS, 2008g)

However, there were no identifiable targets or methods to evaluate the impacts of the structural changes to the central bureaucracy of the DHHS. There was a significant impact on communication and coordination with changes happening at all levels of government and particularly in the national and state government departments of health. There were new policy initiatives being announced at the same time as the negotiation of a national health reform agenda and new funding for prevention. At the local level there was confusion occurring with the decision to amalgamate what had been the Primary Health Services into the new Area Health Services Structure, and the Primary Health Services Management group was dismantled to “fold” into the new structure. These factors compounded communication such that an effective consideration or assessment of outcome for the THP was also impacted.

Layers of central changes to the organisation and reporting structures in DHHS continued to occur until it began to coincide with the planning toward a State election in April 2010. In October 2009, the THP Coordination Group, chaired by the Secretary DHHS, agreed to formally stop the active implementation process for the THP in May 2010. Key points from the Outcomes Realisation and Closure Report (DHHS, 2010b) record the approaches taken to finalise initiatives or transfer responsibilities elsewhere.

A new future stream of work to progress the objectives of the THP that had not yet been realised was promoted with the intention that this would be supported by the next State Government from May 2010. The progress reports that were publically released reframed most of the outstanding initiatives as either completed or transferred to business as usual. The THP Communications Strategy (revised in January 2010) suggested that this transfer to 'business as usual' had been intended from the outset, as in the following extract:

In May 2007 the Minister for Health and Human Services, the Hon Lara Giddings, launched the THP ... to complement a range of policy and planning documents of the Department of Health and Human Services (DHHS, 2010a).

The Implementation Plan covering the period 2007-2010 has successfully achieved completion of two-thirds of all projects. The health reform process has rightly been, and will continue to be, the focus of intense media, community and political attention, interest and scrutiny.

Include the following in key messages:

- stakeholders should hear about the THP, not the PHSP and the CSP separately
- every effort should be made to link relevant health-related announcements and statements back to the THP (e.g. in media releases and speech notes)

Messages supporting the importance of and need for the THP should be used, as follows:

- To meet the challenges faced by our health system today, tomorrow and for years to come, we need a comprehensive and strategic health plan for our state.
- The THP is helping us create a safe, sustainable and efficient health system that provides all Tasmanians with the care they need, when they need it.(DHHS, 2010a)

In terms of health impact, there was an influence from the Health in All Policies conference in 2010²⁵ that was attended by DHHS staff. There was a new narrative for the outcome of the THP that had been signalled in the 2009 Report on Progress for the Tasmania Health Plan by a closing comment issued on behalf of the DHHS Secretary:

On a broader level, Tasmania's Health Plan is now one of several strategies that is helping shape DHHS's reform agenda – an agenda for a sustainable, accessible, efficient and innovative health and human services system. These strategies are now consolidated into one concise directions statement: Strategic Directions 2009–2012. Mr Roberts says this strategy sets out his department's vision, mission and key strategic objectives. 'Strategic Directions 2009–2012 explains how we aim to achieve these objectives and, more importantly, the benefits Tasmanians can expect to experience as a result. In this increasingly difficult financial climate, it is critical that we in DHHS are clear about where we're heading and how we're going to get there. We need to concentrate our efforts to the greatest effect in order deliver sustainable results within the available resources,' he says.

'In future, we will increasingly be focusing much more on health and wellbeing in addition to care and support. This is an approach I am encouraging my staff across all areas of the Agency to embrace and foster. This builds on the Premier's Physical Activity Council agenda. In essence it is all our roles to ensure our patients and clients are at the centre of everything we do and that we will build a health system for which we can all be proud,' Mr Roberts says. (DHHS, 2009c, p77).

Following the HIAP Conference in Adelaide, the THP was described as having been successfully implemented, having provided a foundation for change. The Secretary described the future as providing new and more substantive platforms for change including "Leading the Way in Clinical Leadership", the "Health and Human Services Management and Leadership Programs" and the "Fair and Healthy Tasmania Strategic Review". This resulted in the start of a description of a new 'wave' of development that would come out of the THP.

It is remarkable that any change was achieved given the disruptive changes that happened in the multiple re-structures within DHHS at the same time. Attempts to understand policy change are further complicated with each new process of reform. Hall (1993) distinguishes between orders of change with the first and second of these corresponding to incremental change and the third being a paradigm change that would have required the comprehensive primary health approach that was being promoted by the key actors who started out as senior leaders in ComET in CPRH and became the THP coordination group. This chapter has been useful in demonstrating the complexity of the environment of primary

²⁵ The Adelaide 2010 Health in All Policies International Meeting was co-hosted by the Government of South Australia and the World Health Organisation

health policy. The key actor groups were communicating with layers of actors and actor groups with institutional interests and different understanding of the various ideas as they are represented to them. It is only through the observation of the micro activity of the actors and their institutional activity at work that we can render these dynamics of change transparent, and the lens of DI provides the opportunity to better understand the complexity of what was occurring. The agency of the key actor groups is demonstrable through the documentation and their approaches to deliberation of the tiered service model and the primary health approach and how the discourse is developed and articulated within the relevant networks of actor groups and sub organisations of the DHHS. These underlying beliefs and ideas influence the choices and decisions that are made, especially what to persist with and what to let go. The power of different interests, the media and political appetite for tackling particular issues, public opinion and the opinion of impacted staff, all contribute to the ways that the ideas and the discourse for a primary health approach are developed through the chapter. The changes that were achieved toward understanding and implementing primary health approaches were despite the confusion of the DHHS organisational and structural changes, and probably indicative of the core epistemological communities of the key actor groups with deeply held interests developed over decades. This will be further explored in the next case study chapter.

CHAPTER 6

6 Developing a chronic disease strategy

This third and final case study chapter provides an analysis of the development of a chronic disease strategy in Tasmania that was identified more than a year into the implementation phase for the THP, having been initially dismissed as unnecessary. The empirical material has been selected to highlight the emergence of ideas and the interactive processes of the development of these through the discourse between the actors, particularly within the DHHS. The period covered is from January 2008 to October 2009, and this chapter is particularly concerned with the observation of the dynamics of change. Sabatier's advocacy coalition framework (Sabatier, 1993) explains the processes of the development of policy making through the networks of actors, both within and outside of government agencies, driven by common interests. This is made more complicated when the actors internally within the DHHS are seen as 'nested' within policy coalitions that are external to government and are seen to be competing for progress of particular objectives that are deeply ideational and do not always align with the THP.

In the context of this particular case, the group of senior staff responsible for leading the implementation of the PHSP (the THP Leadership group identified in Figure 16, Chapter 5) could be described as 'sentient agents' (Schmidt, V 2010a; Schmidt, V 2009; Schmidt, VA 2011b) who broadly conceptualised the PHSP as a comprehensive primary health policy approach, aligning with the principles identified as relevant in considering the role of primary healthcare in health promotion in Australia (National Centre for Epidemiology and Population Health, 1992). These principles included balancing healthcare priorities between immediate and long-term needs, and partnership with the secondary and tertiary sectors. This small group of actors can be contrasted to some of the other internal actor groups such as the DHHS Executive who, according to the policy analysis of Gleeson (Gleeson et al., 2010), would have been scrutinizing the strategies of the THP on the basis of performance and efficiency controls. The other group of internal actors that feature in this case study are that of population health services who argued for a greater emphasis on the promotion of health (see Figure 28, this Chapter).

Lin (2003) describes these different perspectives as competing rationalities of cultural, technical or political. The political rationality describes change as being created through the participation and influences of interest groups as well as through the re-working of policy processes. Schmidt brings together the importance of discourse itself in the processes of change, showing how "real actor's' ideas in discursive interactions construct and reconstruct their choices and courses of actions" (Schmidt, VA 2008c p17).

The purpose of this chapter is to interrogate material relating to the development of the ideas through the interactions between the key actors within different institutions as they identify and prosecute policy strategies with the relevant parties.

The DI literature is both constructivist and ideational and provides a means of insight into the endogenous processes of change that are particularly highlighted in this analysis. There are often many versions of fact sheets, information briefings, summary documents and newsletters, and this chapter selects and highlights some of them to consider how they are shaped and changed over the course of the period in which the new policy was established, giving attention to what were the barriers and enablers at each step of the process. In order to do this, the chapter is organised in three main parts. The first section describes the internal governance arrangements and sets the context of the implementation plan for the PHSP and why it did not include a chronic disease strategy. This is followed by the explanation of engagement internally and outside of government by DHHS staff, and by the Minister for Health, and the emergent rationale for needing a common language, described as;

“A blueprint for progressing chronic disease prevention and management in Tasmania, that builds on the Tasmania Health Plan”. (DHHS, 2008h)

The final section of the chapter reveals the changes that were made to the strategy through the processes of discourse and policy development. This is demonstrated and analysed through the written documents and the interpretation through the application of insider knowledge in order to understand what occurred and why.

There had been no intention to develop a specific plan to address chronic diseases when the Implementation Plan was first developed in 2007. The PHSP was premised on the underlying principle of reducing the burden of chronic diseases, as can be seen from the following press release when the plan was first announced by the Minister for Health:

The aim is to ensure we have a primary care network that is responsive to local needs and ensures services that better meet the needs of the community, with an emphasis on prevention and early intervention and chronic disease management. (DPAC, 2006)

6.1 Internal governance arrangements and processes

The need for a specific plan for chronic disease prevention and management arose during the first months of implementation. It became increasingly apparent that the volume of initiatives and projects that were focused on reducing risk, preventing ill-health, increasing screening and early intervention or improving the management of chronic conditions was significant. However, there was no single overall point of reference as a vision or framework for the State, and the problems that this caused were not realised at the outset.

There were several projects and initiatives identified in the first drafts of the PHSP implementation plan that related to chronic disease. In the briefing prepared for Budget Estimates in 2007 (after the launch of the THP in May 2007, but before the first draft of the

PHSP Implementation Plan), the following extract from the briefing (DHHS, 2006c) titled “Primary Health Services Plan Implementation”, gave an indication of what would be implemented to better prevent and manage chronic diseases:

Chronic disease initiatives will include increased support for people with diabetes, through Diabetes Australia Tasmania, with additional allied health nutritionists, an allied health demonstration pilot site in Launceston, and a chronic disease team demonstration site with General Practice ... and additional training in the treatment of chronic disease, particularly diabetes.

Regional Implementation Reference Groups will be established to provide advice to the Steering Committee and will include community members and health consumers, along with local government and non-government representation.

In the first draft of a PHSP Implementation Plan in August 2007, the overview of the themes and goals were identified as follows (DHHS 2007e, p6):

| Theme | Goal |
|--|---|
| The primary health approach | Primary health care that is universally accessible, involves community participation, is integral to and a central function of the country's health system, and is the preferred first level of contact with the health system. |
| Health planning principles | A primary health system that meets the changing needs of the Tasmanian community. |
| Service delivery model | A tiered service delivery model establishing an integrated network of primary health services will provide a sustainable service system for Tasmania. |
| <i>The prevention and management of chronic conditions</i> | <i>Each health centre to have a role in working with key stakeholders and the local community to design and implement programs to support healthy life conditions and choices, and address causes of illness and injury at a local level.</i> |
| General practice | A new relationship between general practice and the Department will be established that better supports the sustainability of the sector and provides additional capacity to respond to the challenges of chronic disease. |
| Rural health centres | A changed and expanded role for rural health centres will be implemented to ensure these services better meet the needs of the Tasmanian population and their local communities. |
| Communication and collaboration between service providers | Improved communication and collaboration between service providers. |
| Community participation | Strengthen community participation in primary health. |
| The health workforce | Sustainability of the health workforce, including a long term strategy to link Tasmania's workforce needs to health care education and training and research. |
| Quality and safety initiatives | That sites have appropriate access to clinical support services, an appropriately skilled and available workforce, equipment, suitable facilities and appropriate capacity to maintain clinical standards. |
| Education and training | The Department will work with the University of Tasmania and other educational providers to provide sustainable health workforce training and development, including a commitment to vocational, undergraduate and postgraduate student placements in primary health care and multidisciplinary settings. |
| Community transport | Access to community transport will be improved. |
| Infrastructure | Facilities will be located and designed for accessibility of clients, adaptable to appropriately house relevant services, established to integrate with other providers and community groups, and networked to support efficient provision of services across client catchments. |

Figure 23: Primary Health Services Plan Implementation Plan, August 2007

Within the first draft of the PHSP Implementation Plan, the prevention and management of chronic disease was identified as "Health Centres against Chronic Disease" in one of the programs of work summarised under the work stream heading of a Primary Health Focus as follows:

Primary Health Focus

1. Primary Health Development
2. Planning for Sustainability
3. Consistent Community Health
4. Rural Health Centre Redevelopment
5. Rural Health Realignment
6. *Health Centres Against Chronic Disease*
7. Safe, Quality Services

The next draft had renamed it as the “Prevention and Management of Chronic Conditions” within more or less the same list of the programs of work that was summarised under the work stream heading of a Primary Health Focus as follows:

1. Primary Health Focus

- 1.1 Primary Health Development
- 1.2 Planning for Sustainability
- 1.3 Consistent Community Health
- 1.4 Safe, Quality Services
- 1.5 Rural Health Centre Redevelopment
- 1.6 *Preventing and Managing Chronic Disease*
- 1.7 Primary Health Partnerships

The leadership for the work stream of a primary health focus, initially identified as the Director of Primary Health and the governing body, was the Primary Health Services Executive group. Each of the work streams were expanded to identify specific projects and outputs in a more detailed outline workplan labelled “Table 3 Program Group, PHSP Theme, Project Objective, Outputs, Timeline and Outcomes” (pages 8–19). Within this the work program for the Prevention and Management of Chronic Conditions was originally laid out as follows (DHHS 2007e, p11):

| Project | Outputs 6–12months | Outputs 1–2 years | Outputs 2–3 years | Outcomes 3+ years |
|---|--|---|---|---|
| 1.6 Preventing and managing chronic disease <i>The objective of this project is to introduce service change in community-based health services.</i> | <ul style="list-style-type: none"> • Development of a statewide health promotion policy • Recruit four new Health Promotion Coordinators • Identifying population groups most at risk of chronic disease, with an initial focus on diabetes, and providing appropriate risk modification and early intervention support programs • Increasing effort in cessation of tobacco smoking specifically targeting those most at risk such as young women, Aboriginal people, or those with mental illness • Develop a policy framework for the provision of youth health services within Primary Health (currently being developed) • Develop collaborative partnerships to encourage young people to adopt healthy lifestyles | <ul style="list-style-type: none"> • Professional development for community health service providers on chronic disease management (especially diabetes) – nurses and health professionals working in primary health services will be able to access diabetes training through accredited training programs • Expansion of the approaches to chronic disease self-management • Greater capacity to prevent and manage diabetes and other chronic diseases at the primary health level • The improvement of e-health infrastructure and support to complement services such as assessment and health coaching for a range of chronic conditions • Dissemination of nutrition resources for practitioners and development and distribution of improved self-help tools for people at risk or with chronic conditions | <ul style="list-style-type: none"> • Development of new models to expand rehabilitation services in the community • Increased access to mental health and alcohol and drug programs in rural areas • Greater access to home based services such as post-acute care and specialised community nursing | Support progress toward goal: Each health centre to have a role in working with key stakeholders and the local community to design and implement programs to support healthy life conditions and choices, and address local causes of illness and injury |

Figure 24 Prevention and management of chronic disease; first draft PHSP Implementation Plan, August 2007

However, this quickly became confusing as the early project outlines were drafted for each initiative and collated for the first meetings of the PHSP Implementation Coordination group. It was evident that some of the same broad areas of work focus were described very

differently by different institutions within DHHS. Descriptions of strategies and approaches demonstrated different language, different professional interests and/or bias, and different principles applied to respective ways of project planning for implementation. They were each valid, but inconsistent with each other because of the different perspectives of the institutions, actor networks, or sub-institutions responsible. For example, the first dot point in the second column of the table above is “development of a statewide health promotion policy”. This was the responsibility of the Population Health Services group in CPRH who had their own culture and operational styles of working that could be broadly distinguished as focused on whole populations rather than the individual patient focus of Primary Health Services. There are several further examples in this extract alone that would either be led by another part of DHHS or require the significant collaboration between different parts of the CPRH in DHHS or with external institutions, for example:

In column 2: “Develop collaborative partnerships to encourage young people to adopt healthy lifestyles” – this requires that youth health services engage with local government and the education department and relevant community sector organisations.

In column 3: “Professional development for community health service providers on chronic disease management (especially diabetes) – nurses and health professionals working in primary health services will be able to access diabetes training through accredited training programs” – this requires engagement with and support of tertiary education; professional organisations including the RACGP, allied health and nursing professional organisations; accreditation agencies; ANF; and the consideration of appropriate distance learning methods.

In column 3: “Greater capacity to prevent and manage diabetes and other chronic diseases at the primary health level” – this requires primary health services working with acute sector diabetes centres, private and public sector allied health professionals such as podiatry, private specialists such as endocrinology, Divisions of General Practice (the Primary Health Organisations at the time, funded by the Australian Government), and general practices.

Depending on the initial author of the project outline, each of these individual projects or initiatives varied greatly. They were identifiably inconsistent when brought together under the program heading of Preventing and Managing Chronic Diseases, and the diversity became more evident when they were brought into the work stream heading for “a Primary Health Approach”.

A review of other work streams reveals that throughout the PHSP Implementation Plan there were many other programs or specific projects and initiatives that had an intentional contribution toward the prevention and management of chronic disease.

In addition to the leadership and governance by the Primary Health Services Executive group, the Director of Primary Health Services would then be responsible to the PHSP Implementation coordination group, and be provided with support by the Deputy Secretary CPRH who had overall responsibility to the DHHS Secretary. Membership of the THP Coordination Steering Committee included the Deputy Secretary responsible for leading the implementation of the Clinical Services Plan, together with the Deputy Secretary CPRH. This in turn was chaired by the DHHS Secretary who was the overall lead for the THP and the delegate of the Minister for Health and Human Services. The project reporting requirements from the outset included written progress and status reports (timeframes, method and templates developed later) and regular progress and 'risk mitigation' meetings between the work stream coordinator or leader and the Deputy Secretary CPRH.

An additional regional governance arrangement that had been raised in Budget Estimates was described in the early implementation planning. It included individual community members who would be recruited through a publicly advertised expression of interest process to form "Tasmania Health Plan Area Implementation Reference Groups" that would meet regularly and assist implementation. In their first iteration they were described as follows:

Tasmania Health Plan Area Implementation Reference Groups – proposed terms of reference

At regular intervals it will be necessary to engage with a wider group than those represented in the various committees proposed in this document. Essentially these forums will provide an invaluable reference point of broad expertise and quality assurance to support the development of program outputs. They also provide an opportunity to move toward consensus among potentially diverse groups of stakeholders.

The THP Area Implementation Reference Forums will inform both PHSP and Clinical Services Plan implementation and be organised on a regional basis.

Background

Tasmania's Health Plan, consisting of the PHSP and the Clinical Services Plan set out key actions to be achieved across both sectors.

Purpose

Area Implementation Reference Forums will provide a regional perspective to the implementation of Tasmania's Health Plan. Half-day meetings will showcase progress in implementing Tasmania's Health Plan in each region, and will provide an

opportunity to discuss and debate future directions. They will function in an advisory, not governance, capacity.

Role and Function

The function of the Area Implementation Reference Forums is to integrate stakeholder and Agency interests to ensure effective delivery of Tasmania's Health Plan.

The role of the Area Implementation Reference Forum is to provide feedback and advice to the appropriate Plan-level Steering Committee for their consideration, in particular to:

- suggest and discuss regional strategies/options that may be used to promote the goals of Tasmania's Health Plan
- identify regional issues to be addressed in the implementation process and provide recommendations addressing the identified issues.

Member Roles

A Chair shall be nominated by the Tasmania's Health Plan Coordination Group for each forum and shall convene the Area Implementation Reference forums as required.

Attendees will be invited on the basis of their individual capacity to provide local intelligence relevant to the implementation of Tasmania's Health Plan and to promote and advocate the directions contained within the plan amongst peers.

In practice, this means they:

- provide input and advice to the program, work streams and projects as appropriate
- help balance conflicting priorities and resources
- consider ideas and issues raised
- communicate these to the wider community.

Meeting Times

The Area Implementation Reference Forums shall meet twice a year or as required. These meetings will take the form of forums for project work stream presentations and feedback.

Meeting Protocols

The Area Implementation Reference Forums agenda, with attached meeting papers, will be distributed at least three working days prior to the next scheduled meeting.

All agenda items must be forwarded to the Secretariat by close of business five working days prior to the next scheduled meeting.

Full copies of the minutes, including attachments, shall be provided to all Reference Forums members no later than five working days following each meeting.

The minutes of each Area Implementation Reference Forum meeting will be monitored and maintained by the Secretariat as a complete record as required under provisions of the *Archives Act 1983*.

Members of the Area Implementation Reference Forums shall not nominate a proxy to attend a meeting if the member is unable to attend.

Review of Terms of Reference

The Area Implementation Reference Forums will be reviewed in January 2008.

Membership

The attendees or membership of the Forums will be determined by the Plan Coordination Group.

These groups were renamed the THP Consultation Forums by the time they met for the first time in each of the regions in May 2008. At the first meeting of the THP Coordination Steering Committee, in December 2007, the newly appointed DHHS Secretary indicated a reluctance to accept the work streams and the governance structures as they had been initially drafted.

The leadership group for the PHSP Implementation presented a background paper to that meeting to summarise the key projects and governance arrangements for both the Clinical Services and Primary Health Services Implementation, authored by the Project Manager Community Health, Primary Health Services were summarised as (DHHS, 2007d, p1):

The Primary Health Services Unit, within the Community Health Services Group, has responsibility for 23 community-based health centres, and regional services such as palliative care, various community services and youth health. It also has 20 small rural health facilities which provide inpatient care and some aged care, and act as a base for

community health and domiciliary services. Fifteen facilities are run by the Department and five facilities are funded by the Department and run by other organisations.

And the governance was summarised as:

Each of the Plans has its own governance structure and this is Tier 2 of the governance structure for the DHHS. Broadly, the Clinical Services Plan is being overseen by the Clinical Services Plan Steering Committee with local project management as appropriate. Overall coordination is through the Director, Acute Care Strategies and Reform. The PHSP Implementation Steering Committee is similarly supported by the Director, Community Health Reform and Implementation. [The author of this thesis.]

Within each Plan, projects have been grouped together in project management arrangements that make use of existing committee structures.

Finally, priority projects may have their own project management governance.

Within the context of the prevention and management of chronic conditions, there had been no progress yet on any of the identified projects other than a preliminary start made on the following project (DHHS 2007d, p3):

Training staff in the primary health approach. A new in-house training program is being developed for primary health staff. It focuses on the primary health approach; health promotion activities; and the prevention, early intervention and management of chronic disease.

The Secretary requested that all of the projects and initiatives for both of the Primary Health and Clinical Services Implementation Plans be brought together into a single Gantt chart so as to provide a summary of all of the progress and interdependencies in time for the meeting in January.

Minutes of the THP Coordination Group meeting 7 December 2007, in reference to the comments about governance and implementation plans, stated simply:

[The Secretary] noted that he will be giving the matters raised in this meeting some consideration prior to his return in January. It was noted that an hour and a half was needed for the next meeting.

Next Meeting: Wednesday 16 January, 1.30 – 3.00 pm, Secretary's Office.

An extract from the Gantt chart summarising the group of projects specifically relating to the prevention and management of chronic disease from the PHSP Implementation Plan, shows how the articulation of these was beginning to change as the implementation process began (see Appendix 2). For example, it was noted at the January Coordination

Group meeting (January 21 2008) that without an overall statewide strategy for chronic disease, there were challenges that were most likely to continue. While the minutes of the meeting do not record this discussion, one of the actions that is relevant is for the Gantt chart to be updated to show how the THP projects link with the projects, activities and existing structures within the rest of the DHHS.

The beginning of the implementation of some of the individual projects and initiatives under the various headings relating to the prevention and management of chronic disease was progressing during the first part of 2008. But consistent progress was challenged by the lack of an overall strategy to guide current and future direction for chronic disease for DHHS.

In the meantime, a concurrent discussion about the governance arrangements for implementation of the THP was taking place, and the following notes are from a meeting with the Secretary in February 2008. This occurred in the midst of site visits to all of the Primary and Community Health Services across Tasmania, and in preparation for the first THP Community Forums (previously referred to as the THP Area Implementation Reference Groups):

Tasmania's Health Plan (THP) was launched in May 2007 by the Minister for Health and Human Services, the Hon Lara Giddings.

Successful implementation of the THP is critical for the Secretary, Minister and the Government.

No one business unit can deliver successful implementation on its own. Successful implementation will only occur if there are appropriate processes, resources and accountability mechanisms.

Governance is critical to these:

- Governance internal to the Health Services (HS) Group e.g. policy or 'above the line' business units having an 'in reach' function to the operational or 'below the line' business units.
- Governance 'cross-cutting' between HS and Statewide System Development (SSD) Groups and other parts of the Agency, including linkages with population health, CNO, corporate functions.
- Governance 'cross-cutting' between the Agency and external stakeholders e.g. General Practice, University of Tasmania, Australian Government, other parts of the State Government.

Some staff, including the author, expressed uncertainty for how this would be implemented in practice. At the PHSP Steering Committee meeting in December 2007 (DHHS, 2007d) it was agreed to document all of the chronic disease projects listed under the Primary Health Services and Clinical Services Implementation Plans with a brief description of each and their relative timelines and interdependencies. As a background to the discussion that was subsequently formally held at the THP Coordination meeting in March, the Director of Population Health raised the following points at a meeting with the Director of Community Health Services Reform and Implementation (the author) and the Director of Primary Health, together with Deputy Secretary CPRH, as follows:

The Primary Health Services Plan Steering Committee meeting in December 2007 recommended the development of an action plan to include all the chronic disease initiatives that projects are listed under in the Primary Health Services and Clinical Services Implementation Plans.

Given the implications of the continuing prevalence of chronic disease there is a pressing need to improve the prevention and management of chronic disease across the health system and in particular to improve planning and coordination.

There is a wide range of practice and activity in the area of chronic disease both within Government and externally. There are a large number of projects and initiatives outlined in the THP which focus on chronic disease. The responsibility for prevention and management of chronic disease is identified across the internal service operating areas of DHHS, and externally with general practice, the private sector and NGOs.

The big ticket item that is missing is an overall statewide strategy for chronic disease. Without it there is nothing to guide planning, implementation, and evaluation; no identified principles, goals and actions; and no agreement on ways to progress and engage with relevant stakeholders both within the Department and externally on agreed ways forward.

At the next meeting of the Steering Committee on 16 June 2008, the Director of the Clinical Networks was included because they were being established under the Clinical Services part of the THP, and it was anticipated that the implementation of a Chronic Disease Strategy could be delivered through the mechanism of a clinical network.

The governance for the development of a Chronic Disease Strategy was endorsed at a meeting on 16 June 2008, and represented as follows:

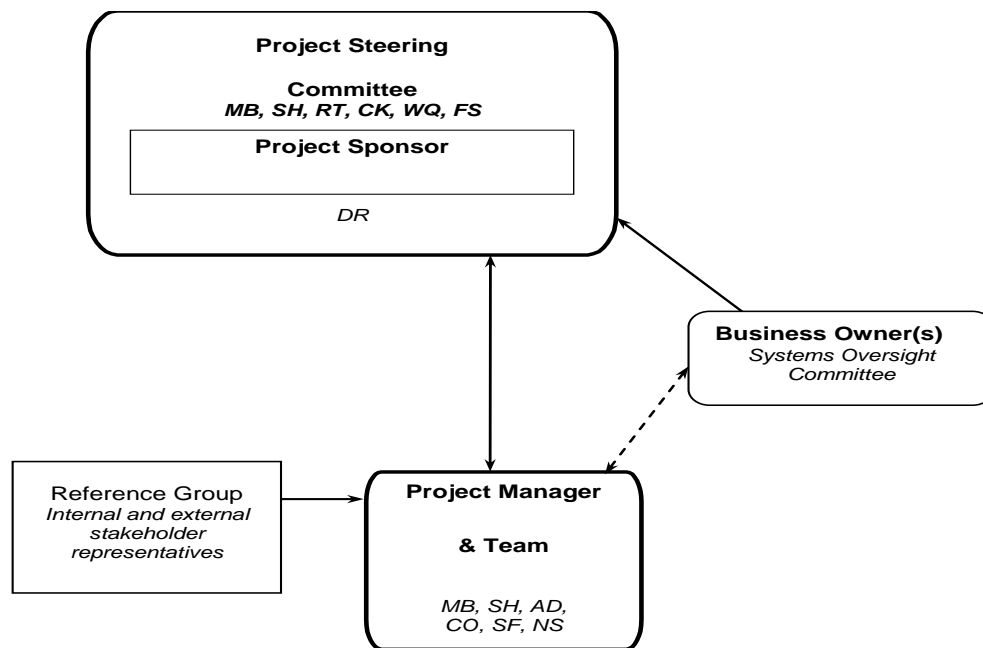


Figure 25 Governance for the Chronic Disease Strategy as at June 2008

The governance refers to members of the Steering Committee by their initials, and the project sponsor was the DHHS Secretary. The Business Owner was the Systems Oversight Committee (the name now given to the THP Coordination Group). Members of the Project Team included systems development staff, and staff from population health services. It was also intended to establish an initial reference group that would comprise representatives from the following groups:

- DHHS Clinicians and Managers
- NGO Sector (Chronic Disease Prevention Alliance)
- General Practice
- University of Tasmania and Menzies Research Institute

The projects that were identified as interdependent to the development of a chronic disease strategy were:

- Health Promotion Framework
- Chronic Disease Clinical Network
- Primary Health Partnerships
- Consumer Engagement Framework
- Chronic Disease Self-Management Framework

It was initially anticipated that the following hierarchy represented the context of the Chronic Disease Strategy with the other related policy development work:

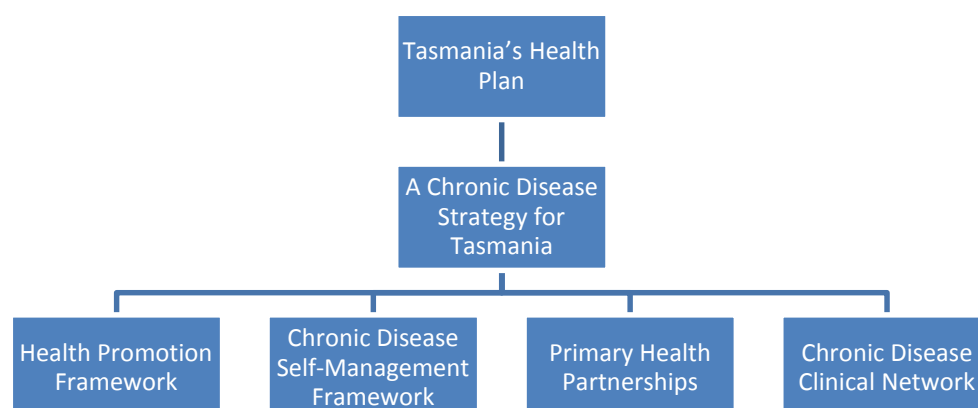


Figure 26 Hierarchy of policy context for the Chronic Disease Strategy as at May 2008

At the July 2008 Meeting of the Steering Committee the membership had extended to include the CEO of the Diabetes Australia Tasmania branch, who was also the Chair of the Tasmanian Chronic Disease Prevention Alliance. The meeting noted the relationship with the Australian Government in the area of chronic disease prevention and management, with the expectation that the Council of Australian Government (COAG) would release a National Chronic Disease Strategy in draft by October 2008. It also noted that 'prevention' and 'chronic disease' were to be added into the new Australian Health Care Agreement, with the potential for a new partnership agreement to fund new action in these areas of health policy.

There had been much discussion about the model that would be the most appropriate to underpin the principles or goals for the chronic disease strategy, and the Background Paper (DHHS, 2008b) had assessed the range of options nationally and internationally. The Chronic Care Model developed by Wagner (1998) (See Figure 27) was most widely known, applied and understood, and the Steering Committee agreed to adopt it. There was also consideration of the Expanded Care Model (see Figure 28), but the differences of perspective in terms of individual or population health approaches resulted in the first model being the more straight-forward to progress with.

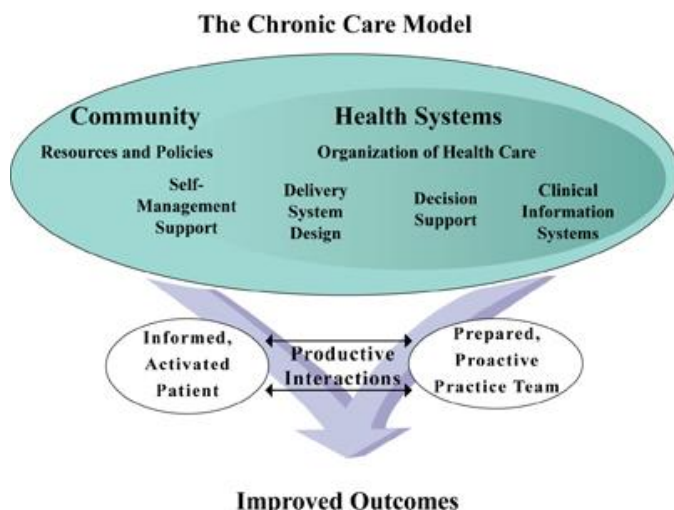


Figure 27 Chronic Care Model (Wagner, 1998)

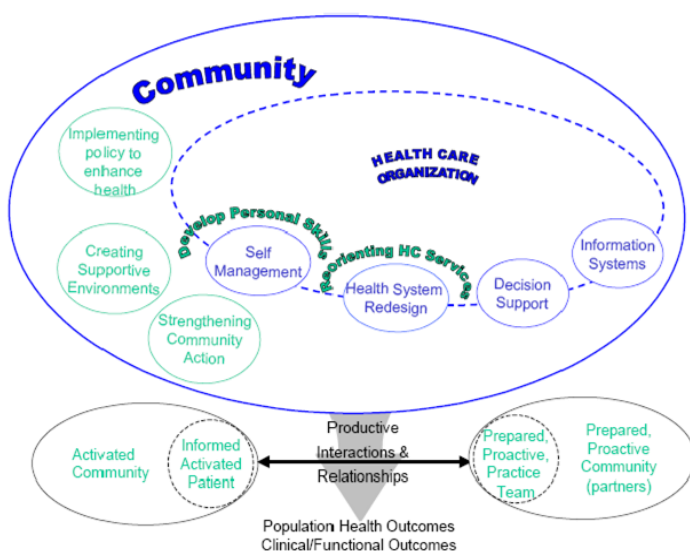


Figure 28 Expanded Chronic Care Model (Ministry of Planning, 2003)

The system changes in both the Chronic Care Model and the Expanded version were designed to describe how the overall health improvement for people living with, or at risk of, chronic diseases could be improved. The intention of the model is to illustrate the benefit of bringing about 'productive interactions' among individuals and families, practice teams, and communities. The benefit of these productive interactions is improved clinical, functional and population health outcomes. For interactions to be productive, individuals and families must be informed, activated practice teams must be prepared and proactive, and communities themselves must be informed. In practice, this would entail developing the necessary expertise, client information, time, decision support, and proper mix of professional skills to assure effective clinical management, self-management support, and prevention. And, in turn, that individuals and their families would understand the disease

process, and have the confidence and capacity to participate fully in planning and self-managing their health in their interactions with practice teams and community providers. Prepared and proactive community partners would also have the necessary expertise, information, time and resources, to work with health care organisations to provide effective management and prevention. The Expanded model (Figure 28) takes the extension to the engagement of improving health in the community through the full range of changes that create supportive environments and create healthy public policies.

The Business Plan (DHHS 2008i.) was amended to reflect the agreed changes in membership and governance, and to include the appointment of an external consultant to facilitate community consultation and the establishment of a virtual network that would (DHHS 2008i, p17):

[...] provide key internal and external stakeholders with the opportunity to input into the development of the Chronic Disease Strategy. The Virtual Network's principle means of communication will be via email, which will allow a greater range of membership and exchange of information than a traditional reference group. A key role will be to comment on policy development papers and input into the community consultation process. Terms of reference and engagement processes for the virtual network will be developed in consultation with the group.

The hierarchy of the context of the Chronic Disease Strategy was amended to take account of the national policy context as follows:

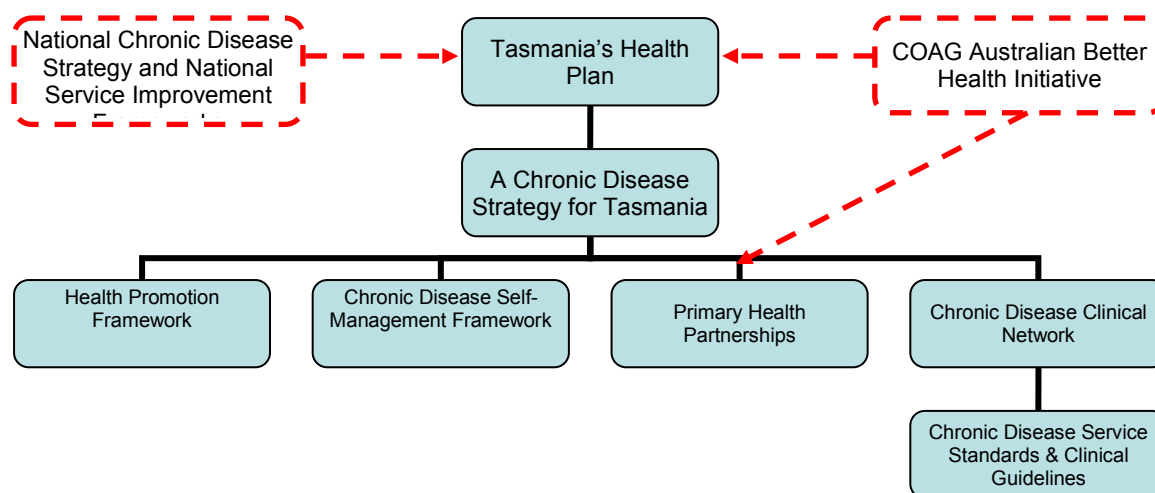


Figure 29 State and National policy context for the Chronic Disease Strategy as at June 2008

By August 2008 there was a Discussion Paper that provided a literature and policy review of approaches to the prevention and management of chronic diseases across other parts of Australia and internationally. This was used to prompt discussion with internal and external stakeholders. The Virtual Network had been launched and already had 150 members ahead

of the intended Chronic Diseases Clinical Network that would be supported by the Director of Clinical Networks.

6.2 Engaging with others – internal and community stakeholders

The initial press release (Department of Premier and Cabinet Tasmania [DPAC], 2006) gave an indication of the intention to engage:

Lara Giddings, MHA
Minister for Health and Human Services
Wednesday, 27 September 2006

Health and Human Services Minister Lara Giddings today said that Tasmanians would benefit from the development of a statewide plan for primary health services.

Primary health services are community-based health services outside the acute care hospitals, and include GPs, allied health services and rural hospitals.

Ms Giddings said work was now underway on the plan, which would have a 10-year outlook and would dovetail with the Tasmanian Clinical Services Plan currently being prepared to provide a comprehensive statewide framework for health services.

‘Primary health is a critical part of the health care system and getting it right is essential if we are to improve individual health and relieve pressure on acute care services,’ Ms Giddings said.

‘While traditionally primary health providers have focused on the care of the sick, there is strong support at a national level to extend the emphasis to the development of health.

‘This includes a focus on population as well as individual health, health promotion and education, and community involvement, improving the continuity of care and integrating prevention.’

Ms Giddings said the statewide Primary Care Plan would be developed in collaboration with GPs and other clinicians, and there would be opportunity for community input.

‘The plan will examine population trends and demand patterns and identify safe and sustainable services based on local primary care networks, including government, private and community sector services.

The plan will address linkages between primary health and the major hospitals, as well as mental health, alcohol and drug, population health and ambulance services.

The aim is to ensure we have a primary care network that is responsive to local needs and ensures:

- services that better meet the needs of the community with an emphasis on prevention and early intervention and *chronic disease management*
- equitable services with clear entry points for access
- improved linkages with the acute hospital system
- a sustainable primary health workforce
- appropriate standards of quality and safety
- effective use of resources and funding
- ongoing community engagement '

Ms Giddings said community and stakeholder consultation would begin next month and the PHSP was expected to be completed by Christmas.

This thinking was developed further in the paper provided to the THP Coordination meeting on 8 March 2008 (DHHS, 2008h) that recommended the establishment of a Steering Committee to develop a Statewide Chronic Disease Strategy. The following key issues were presented:

- There is a high risk in continuing without an overall strategy to guide directions; that activity and outcomes will not be coordinated, lasting and effective; and that key stakeholders from across the health system will not be fully engaged in the process.
- The Primary Health Services Implementation Plan identifies the delivery of a *statewide chronic disease self-management plan* as a key performance indicator. Ideally this plan would be developed in the context of a statewide chronic disease strategy and acknowledging that self-management is one key element in managing chronic disease alongside a number of other strategies.
- There is a risk in progressing a self-management plan prior to development of clear directions overall for chronic disease.
- The 2005 DHHS policy framework *Strengthening the Prevention and Management of Chronic Conditions* (DHHS, 2005b) is the most current strategic document for chronic disease in Tasmania. This document is valuable as a broad policy framework and the next stage is to focus on the strategic coordination of actions and implementation.
- There is a useful example from Queensland Health where a statewide Queensland Chronic Disease Strategy 2005-2015 was developed and then in 2007 a Queensland Framework for Self-Management developed.

- In order to develop a statewide chronic disease strategy, experiences from interstate (and from recent development of the Health Promotion Framework internally) indicate the need for consultation and engagement with key stakeholders both inside and outside of the Department. This is particularly the case for chronic disease given that key stakeholders include both hospital and community health areas, general practice, private providers and non-government organisations.

The first meeting to formally establish the approach to develop a chronic disease strategy was on 14 May 2008 with a small working group comprising the Director Community Health Reform (the author), Deputy Secretary State-wide System Development, Director of Population Health, and the Deputy Secretary for Health Services. The background paper provided to this first meeting included the following recommendations:

1. Note the current lack of an overall strategy to guide present and future directions to address chronic disease.
2. Note and provide input on the development of a Statewide Chronic Disease Strategy that will include:
 - a. Vision, principles and goals
 - b. A blueprint for progressing chronic disease prevention and management in Tasmania, that builds on the Tasmania Health Plan
 - c. Service standards
 - d. Adoption of relevant clinical guidelines or patient care pathways.
3. Note that the Deputy Secretary SSD [*the title now given to the former Deputy Secretary CPRH*] will lead this work which will broadly cover:
 - a. A review of the work already undertaken nationally, in Tasmania and elsewhere, determination of its Tasmanian applicability, engagement of clinicians across the sector, and endorsement.
4. Comment on the process and timeframes for the development of a Chronic Disease Strategy for Tasmania.

All of these recommendations were accepted and the proposal was summarised as follows:

| <i>Id</i> | Description | Who | Scheduled Start | Scheduled Finish | Predecessor²⁶ |
|------------------|--|--------------------------|------------------------|-------------------------|---------------------------------|
| 1 | Establish the scope of reference nationally and elsewhere, review and determine its applicability | MB, CK, RT | April 08 | June 08 | |
| 2 | Communications strategy developed and endorsed | MB | April 08 | May 08 | |
| 3. | Engagement with key stakeholders with proposal, process and timing for Strategy | SSD ²⁷ | May 08 | June 08 | 1,2 |
| 4 | Development of outline strategy, including vision, service standards and suggestions for guidelines | Internal reference group | June 2008 | June 2008 | 1 |
| 5 | Outline provided for discussion and engagement with key stakeholders in hospital, community, general practice, private sector and NGOs | SSD | July 08 | September 08 | 4 |
| 6 | Strategy developed and re-presented as final draft to key stakeholders | MB | October 08 | November 08 | 5 |
| 7 | Final strategy published and launched | MB | November 08 | December 08 | 6 |

The virtual network

Email invitations to join the Virtual Network for the Chronic Disease Strategy were sent to an initial contact mailing list of approximately 119 people who were health professionals employed in various parts of DHHS, community members on the THP Consultation Forums, Community Sector organisations, the Network of GP Divisions, and Partners in Health Management Committee members. The first email 'newsletter' read as follows:

Good Morning,

WELCOME TO THE CHRONIC DISEASE STRATEGY FOR TASMANIA VIRTUAL NETWORK

Thank you for your interest in joining the Chronic Disease Strategy for Tasmania Virtual Network. As a member of the Virtual Network you will receive regular email correspondence concerning the development of a Chronic Disease Strategy for

²⁶ The activities appearing in the preceding column must be completed before the activity described can begin.

²⁷ SSD is Statewide System Development, the latest name given to the leadership group responsible for the whole of the THP implementation

Tasmania. You will also have the opportunity to provide input and advice on the draft strategy as it develops and to participate in face-to-face consultation sessions that will be held in a number of locations throughout the state. For a summary of the project, including an outline of the policy development process and timeframes, see the attached flyer.

WE WOULD LIKE YOUR INPUT

In this initial correspondence we are seeking your views on the following documents:

1. *Chronic Disease Strategy for Tasmania Virtual Network – Draft Terms of Reference*

This document outlines the proposed role, membership and operational arrangements for the Virtual Network. Please indicate whether you are supportive of the draft Terms of Reference or whether there are changes or additions you would like to see made.

2. *Project Background Paper – A Comparison of Australian and International Policy and Models of Care*

The project background paper presents a sample of current Australian and international chronic disease policy and approaches. This includes a comparison of:

- a. the objectives, principles and actions of chronic disease policies
- b. broad chronic disease frameworks (e.g. the Wagner Chronic Care Model) and service delivery models (e.g. the Kaiser Permanente Triangle)
- c. service standards and clinical guidelines.

We would like your thoughts on the information presented in the background paper.

Appendix B includes a list of consultation questions to help prompt your thoughts. Please send us your comments against any or all of these questions.

This feedback will be used to inform the development of a first draft of a Chronic Disease Strategy for Tasmania which will again be circulated to the Virtual Network for comment, prior to any consultation sessions with the broader community.

The deadline for comments against both documents is *Friday 29 August 2008* (2½ weeks). The Chronic Disease Strategy Project Team will then circulate a final version of the Virtual Networks Terms of Reference and a summary of feedback received in response to the background paper.

HOW TO SEND US YOUR COMMENTS

When emailing your feedback please reply only to chronicdisease.strategy@dhhs.tas.gov.au. Do not hit 'reply to all' as the volume of emails may overburden some user's email accounts. The Chronic Disease Strategy Project Team will send a weekly summary of comments received that is compiled into a single document.

INVITE OTHERS TO PARTICIPATE

Please feel free to forward this email onto any colleagues you know who may be interested in joining the Virtual Network. To join the email distribution list new members simply need to send an email to chronicdisease.strategy@dhhs.tas.gov.au asking to do so. You can also opt to leave the Virtual Network at any stage by sending a request to the same address.

Kind regards

The Consultation Questions in Appendix B of the Background paper were as follows:

Development of a Chronic Disease Strategy for Tasmania Consultation Questions

- What is your response to the background paper? Have we missed anything? Do you know of any new or emerging approaches to chronic disease that we have not identified?
- Are there any particular principles or models of care for chronic disease which you would recommend for Tasmania?
- What are the strategies and actions that you would like to see to improve chronic disease prevention and management in Tasmania? Are there any particular services or practices that need to be improved?
- Where do you see the greatest need? Are there any particular illnesses or risk factors that need to be prioritised? Are there any population groups that have specific needs?
- Is there any support that you or your organisation needs to assist in the prevention and management of chronic disease? For example, training needs, policy environment, information, workforce development, clinical guideline tools?

- Are there any other issues that need to be addressed in the Tasmanian chronic disease strategy?

The initial feedback on the Background Paper and the consultation questions provided material to start drafting the outline of a strategy. A letter was drafted to be sent from the Deputy Secretary to invite contribution to the initial draft strategy through written and face-to-face feedback. The Strategy was summarised in an information flyer (most of the projects under the THP had a fact sheet in a similar format available in print form and on the internet, under Future Health).

While population health was relatively good in Tasmania, the State of Public Health Report (DHHS 2008) demonstrated that there were significant inequalities in health between population groups within Tasmania, and also between Tasmania and Australia as a whole. And so the expected outcomes of the development of a state-wide chronic disease strategy were identified as needing to include:

- Services that would be designed and delivered based on common understanding, priorities and an approach to chronic disease prevention and management.
- The adoption of evidence-informed best practice for chronic disease prevention and management across the continuum of Tasmanian health services.
- Key stakeholder support and buy in for an agreed direction towards the prevention and management of chronic disease in Tasmania.
- Greater integration of chronic disease prevention and management across the continuum of care.
- Consistency across DHHS service agreements with non-government organisations relating to chronic disease.

A paper to the THP Coordination group reported the following from a review of the activities that had already been completed or were in progress:

- *The establishment of a Project Team and High Level Steering Committee* to oversee the policy development process. Steering Committee membership is comprised of senior DHHS managers and the Chair of the Chronic Disease Prevention Alliance (representing the non-government sector).
- *The development of a Business Plan and Communications Strategy* to set out project phases, milestones and time frames.
- *A review of Australian and International Chronic Disease Policy and Models of Care* which identifies current thinking and best practice in chronic disease prevention and management for possible use in Tasmania.

What will happen next?

- *A Virtual Network of Key Stakeholders* is being established to input into the development of the draft strategy and to provide advice on the consultation process.
- *A Draft Strategy will be released*, together with a call for written submissions in response to the directions proposed in the draft document.
- *A series of Consultation Sessions* regarding the draft strategy will be coordinated across the state.
- *A Ministerial launch* of the final policy document is anticipated in December 2008.

Consultation

Interested parties are encouraged to get involved by joining the Virtual Network, attending a consultation session or submitting a written response to the draft strategy once it is released.

To get involved or simply find out more information, contact the Policy Analyst, DHHS by phoning 6233 7853 or email chronicdisease.strategy@dhhs.tas.gov.au. (DHHS, 2008h)

The advertisement to submit a proposal for facilitation of the consultancy for the Community Consultation for the Chronic Disease Strategy was advertised in August and with the intention to hold at least 12 half day sessions around Tasmania in October 2008. The advertisement described this as follows:

Quotations are sought for an external consultant to facilitate 13 half-day community consultation sessions across Tasmania during October 2008. The consultation sessions are being undertaken for the purpose of developing a statewide chronic disease strategy. The consultation sessions are to be held in Tasmania's three major acute hospitals and seven primary health management areas. Sessions will also be held with the General Practice Networks Policy Group, the Tasmanian Chronic Disease Prevention Alliance and the University of Tasmania's Chronic Disease Prevention Alliance. (DHHS, 2008h)

The internal deliberations to establish the need for a coordinated approach to chronic disease were assisted by the discourse at the national and international level. Seminal to gaining traction for a strategy was the Background Paper (DHHS, 2008b) that identified the policy work in other parts of Australia, how this aligned with the nation policy and, in turn, with chronic disease strategies being applied internationally. Taking this conceptual thinking

externally was positively received by the central bureaucracy, the THP Coordination Group and the Minister for Health, who supported the establishment of a Virtual Network.

6.3 Changes in the strategy – influenced by feedback and by national policy

There was development of a national strategy for chronic diseases occurring at the same time as the early implementation activity started for the PHSP Implementation Plan. The Secretary requested establishment of some meaningful reporting indicators for the THP at the Coordination Group meeting in January 2008. Members of the key leadership group for the PHSP (see Figure 7 Chapter 3) discussed this together and brainstormed ideas against the principles from the Health Plan (DHHS, 2007k, p27):

Tasmania's health services will be:

- accessible as close as possible to where people live, providing services can be delivered safely, effectively and at an acceptable cost
- appropriate to community needs
- client- and family-focused
- integrated, through effective service coordination and partnerships between providers
- designed for sustainability.

Where services cannot be delivered safely, effectively and at an acceptable cost locally, access will be facilitated through service coordination, transport assistance and other appropriate support.

It is recognised that it is difficult to achieve equal levels of performance across each of the domains identified above and that health service delivery decisions often represent trade-offs between access, safety, affordability and effectiveness.

The following suggestions were presented to the THP Coordination Group meeting on 18 February 2008 as follows:

Access

- Items that people might value might include:
 - Improved access to mental health services in rural areas
 - Improved access to priority services such as rehabilitation, diabetes, elective surgery

- Improved access to healthy lifestyle programs
- Improved access to community transport needed for health reasons
- Access can be *measured* in terms of waiting times for services and scope of services available at the local level, for example:
 - Waiting times for podiatry, diabetes education in specific communities where service change has been undertaken e.g. Rosebery (West Coast of Tasmania)
 - Waiting times for elective surgery
 - Treatments per mental health client in a three-month period, rural compared with urban
 - Percentage of communities where Local Government sponsored health lifestyle programs are in place.

The first and last of these were particularly relevant to the chronic diseases strategy. Rural communities have consistently reported concerns about the way rural patients receive care in the major hospitals concerning, for example, lack of coordination of outpatient appointments or a lack of understanding about the support required to ensure patients can return home safely after discharge (DHHS, 2007h, p58).

The community (expressed through organisations that were members of the Tasmania Chronic Diseases Prevention Alliance, for example) had become increasingly aware of the need for improvements in the health status of Tasmanians in relation to particular disease types. They recognised that Tasmania was performing poorly in comparison with other jurisdictions in Australia in relation to cancer, diabetes, cardiovascular disease in terms of incidence and prevalence. And yet at the same time there was also recognition that self-reported individual health data reflected a broad societal sense of community health and wellbeing in Tasmania. There was a strong interest in the development of the proposed Primary Health Partnerships that would link services managed or funded by the Australian Government, local government, non-government organisations, general practice and the DHHS (DHHS, 2007h, p35). This concept was intended to foster greater coordination of services within each area, to develop clinical links between local services in order to enhance the quality and safety of services, to support workforce sustainability, and to achieve greater efficiency in the use of resources. Local emphasis will enable greater involvement of the community in health service planning and improvement.

Following discussion of the factors that would influence reporting, and the development of relevant indicators, it was acknowledged that a high level steering committee should be established to further explore the implications for a chronic diseases strategy. The membership was to include the two Deputy Secretaries and the Director of Public and Population Health.

A scope of reference will include a review of the work that has already been undertaken nationally, in Tasmania and elsewhere, and determine its applicability to Tasmania. This includes:

- National Chronic Disease Strategy and the disease specific National Service Improvement Frameworks (these provide detail for each of the conditions such as diabetes and cardio vascular disease).
- Clinical Standards and guidelines for disease specific groups.
- The 2005 DHHS policy framework Strengthening the Prevention and Management of Chronic Conditions (DHHS, 2005b) which *is* the most current strategic document for chronic disease in Tasmania, and does not include the current strategy thinking.

The proposed Chronic Disease Strategy for Tasmania needs to take account of, and link with, the performance indicators for the new Health Care agreement which are being developed nationally through the NPAH.

The internal confirmation of the strategy and its proposed content would be undertaken with key stakeholders, including: primary health, population health, acute care strategies and services, and members or potential members of a virtual chronic disease network.

The minutes of the first meeting of the Steering Committee on 14 May 2008 (DHHS, 2008c) convey an active and wide-ranging discussion which could, in part, be attributed to the range of papers that were provided as pre-reading to stimulate the discussion. The minutes also reflect that there were different perspectives with regard to the focus for a potential Chronic Disease Strategy within the key senior leadership group of the DHHS. For example, an overview of a meeting in Queensland had discussed new and potential primary care funding models and it was suggested this could be included in the strategy. This was noted in the minutes as follows:

The meeting discussed the possible provision of packages of care to people with chronic disease to enable them to manage their condition. For example, a person with a chronic mental condition might be entitled to a standard number of appointments with a psychologist, based on their level of need (Swerissen, 2008). This led to a discussion about whether Tasmania might be a suitable location to run a chronic conditions trial that combined or integrated funding. It was suggested that there would be a high level of support from the non-government sector, and possibly the Divisions of General Practice for such a trial in Tasmania. The Divisions are being funded to potentially coordinate access to lifestyle programs.

In contrast, there was discussion about the merits of various models for chronic disease prevention and management adopted in the current strategies and policies in other parts of Australia and internationally. These are recorded as follows:

Australian and overseas countries have adopted the same or similar evidence-based best practice models for the prevention and management of chronic disease (e.g. Wagner, Kaiser Permanente). This information was also presented in tabular format and it was explained that the Queensland conceptual framework model for chronic disease prevention and management had emerged as a potential model for use by Tasmania. The Queensland model is based on the widely accepted Wagner Chronic Care Model, but also incorporates the continuum of care and elements of a number of other recent models.

There was discussion about the possible application of clinical standards and whether a UK based website 'Map of Medicine' that provides clinical pathways online could be adapted for use in Tasmania. This prompted discussion about the National Service Improvement Frameworks that had been established with the intergovernmental leadership driven through Population Health Services and had included clinical standards that were intended for use across Australia.

There was an overlap in the discourse occurring between the different internal stakeholder organisations of DHHS driven by the ideational difference between health promotion and chronic disease prevention. This was becoming more evident as the two complementary strategies were beginning to take form. Population Health Services was concerned and a paper was provided to the Steering Committee meeting of 15 August 2008 that recommended:

That steps be identified to ensure ongoing communication and interface between the development of these two strategies.

One of the next steps agreed at that first meeting was to further develop the initial research into comparing what was being done in other parts of Australia and internationally. Population Health Services agreed to assist the Statewide Systems Development Unit (as the leadership group for the THP was now called) in the development of a Discussion Paper.

The differences identified represent the heart of the differences in discourse between a population health approach to that of treating individual patients. A meeting paper for the August meeting articulates these differences as follows:

[...] This raises the issue in terms of the scope we wish to take for the [Health Promotion] Framework in Tasmania and how it overlaps and relates to the work of the [Chronic Disease] Strategy.

As part of a cultural change within DHHS we are keen to promote the concept of working with clients in ‘health promoting ways’ to overcome the concept that ‘health promotion’ is limited to events or group work, and that it can occur along a whole continuum from one-to-one client work to broader community approaches.

...

A large proportion of the clients that DHHS staff in Primary Care work with, already have established disease, or controlled chronic disease. If we are looking to introduce the concept of ‘working in health promoting ways’ across the whole continuum, can we afford to define the scope of the HP framework as only relating to the well population and those at risk?

... or

Do we need to limit the scope of both of these frameworks to ‘health promotion’, taking first two groups (*Well Population and At Risk*) as Victoria has done, acknowledging that health promotion is along the continuum and looking at health promotion in the last two groups (*Established Disease and Managed Disease*) as part of the Chronic Disease Strategy? Would this ensure a broader health promotion focus that includes social determinants of health and less of a disease management focus?

The following diagram is taken from “Health Promotion Priorities for Victoria: a Discussion Paper”, from the Department of Human Services Victoria (date not known and included with Population Health Services paper to the CD Steering Committee meeting of 15 August 2008):

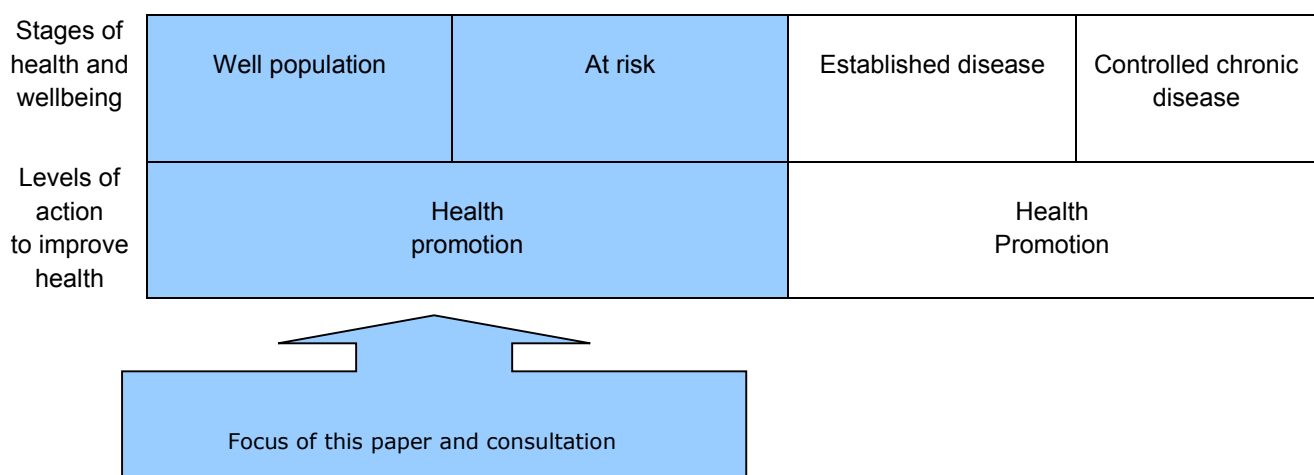


Figure 30 Levels of action and stages of health

Figure 28 is focussed on the activities of health promotion, whereas Figure 29 places a greater emphasis on the activities that prevent and manage disease rather than the promotion of health itself.

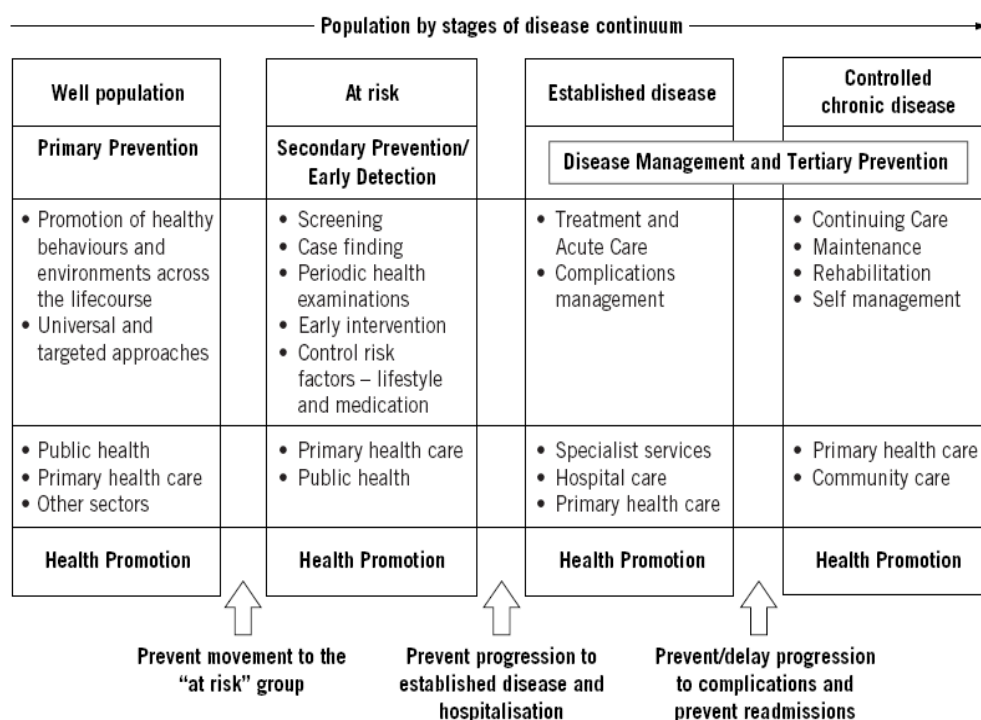


Figure 31 Adapted from the National Public Health Partnership Document: Background Paper (National Public Health Partnership, 2001)

The discussion was recorded in the minutes of the meeting as follows:

4. Joint Discussion – Tasmanian Chronic Disease Strategy Steering Committee and Health Promotion Framework Working Group (paper)

[Population Health] outlined the background leading to the development of the HPF [Health Promotion Framework] and presented the latest draft. It was explained that the HPF Working Group is now focused on developing supporting documents that will help staff to implement the framework. In doing this, DHHS has received permission to base materials on a Background Paper developed by Department of Human Services Victoria.

The Working Group is considering the scope of the HPF and whether to adopt the same approach as Vic Health. That is, whether to focus health promotion efforts on the well and at risk population, or whether to also include those with established and/or controlled chronic disease. Different jurisdictions approach this dilemma in

different ways. For example, Western Australia's current approach is to focus health promotion on disease-related risk factors, but to also acknowledge the broader determinants of health.

The group discussed the need to ensure consistency across the HPF and the TCDS [Tasmania Chronic Disease Strategy]. It was thought that the two documents are separate concepts, but that there is significant overlap in their scope. The use of consistent language across the two documents was considered important. It was agreed that the two groups will need to communicate with one another as both policies develop and that this should be easily achieved given that the HPF Working Group is represented on the TCDS Project Team. The two groups can raise any issues with the other by tabling them at meetings. It was also agreed that the two documents should reference each other in any communication materials.

The Director of Clinical Networks noted that there was an emergent need to consider people with disabilities within the HPF as their risk factor profile is similar to Aboriginal and Torres Strait Islander populations; that is, linked to health inequality, community marginalisation and low socioeconomic status.

[Population Health] referred to the Comprehensive Model of Chronic Disease Prevention and Control which was developed by the National Public Health Partnership (see Figure 30). This shows the potential scope of health promotion activities across the chronic disease continuum. The Director of Population Health services noted that Population Health revised this model for Tasmania in the "Strengthening the Prevention and Management of Chronic Conditions Policy Framework" in 2005 (DHHS, 2005b), and it was agreed to look at whether this revised model would be appropriate for inclusion in the TCDS and HPF.

It was also noted that the State/National Chronic Disease Policy Context diagram contained within the Background Paper needs to be revised (e.g. is the HPF an output of the CDS or do the two overlap? Where does the Diabetes Action Plan sit?).

The CD Steering Committee took account of the Working Group discussion and feedback from the Network, and endorsed a framework for chronic conditions called *Connecting Care* (DHHS, 2009e). Further changes as a result of restructures within the Department meant that the implementation was delayed, but eventually it was organised through the establishment of clinical networks. The Chronic Diseases Clinical Network had a membership of GPs and hospital specialists, allied health staff, consumers, and representatives from Chronic Disease organisations such as the Heart Foundation and the Tasmania branch of Diabetes Australia. Much of this policy development continues, and continues to be both progressed and contested within the State and at the National level as policy emphasis and priorities change.

The chapter has drawn from a more detailed set of materials within DHHS that have included personal notes of the author, minutes of meetings, and documents provided publically to develop the discourse for a chronic disease strategy. This variety and combination of documents demonstrate the dynamics of the agenda setting and establishment of a policy position. The material in this chapter has revealed the processes through which ideas take form through the deliberated action of the small group of actors identified at the start of the chapter as those leading the implementation of the PHSP. This is the process of discourse which, according to Schmidt (2008b, p309), “is a more versatile and overarching concept than ideas” because it is about conveying meaning in order to pursue a course, or courses of action. The individuals at the very centre of the deliberation of the early implementation process were creating, elaborating and justifying the policy and program ideas. This, Schmidt argues, is the loose connection of ‘epistemic communities’, “advocacy coalitions” or “discourse coalitions” (Schmidt, VA 2008b, p310) who coordinate their agreement with one another on the basis of cognitive or normative ideas.

CHAPTER 7

7 Discussion

This chapter brings together the problems identified in the introductory chapter that explained the context of a comprehensive primary health policy change and the contestability of the field with multiple actors in the system that sit outside of traditional health organisations. The subsequent chapter reviewed the relevant literature concluding that DI provided a valuable theoretical lens that brought together the ideational and discourse dimensions of health policy change with an understanding of the contextual impact of institutions. The intention was to better understand the dynamics of change at work, and each of the case study chapters analysed the deliberations and processes of change through the lens of DI. The case study chapters interpreted the empirical documents and other material observations from the Tasmania Health Plan during the period 2005-2010 with particular reference to whether policy changes in primary health services were occurring and how. The term primary health policy is defined broadly to be the comprehensive approach that was articulated in the latter part of Chapter 1, and includes the concepts of 'healthy public policy' and 'health in all' policy.

These dynamics of health policy change were analysed using two of the three core research questions for each of the three case study chapters, and these questions were informed by DI and identified at the close of Chapter 2 (see section 2.5). Each of the case studies followed the same outline structure that considered the institutional arrangements, the engagement strategies and the assessment of impact, with a different focus on the policy cycle of the THP for each chapter. The structure of the analysis was described in Chapter 3 and introduced at the start of Chapter 1 in Figure 1. This is re-presented in Figure 30 that follows, and the three research questions are used to structure the discussion in this chapter.

| Research questions | Case study title | Focus of the case material for each chapter | Bringing questions + theory + case material together |
|---|--|--|--|
| 1. How are policy discourses constructed in the coordinative sphere? | Establishing the case for a primary health services plan | Getting onto the policy agenda | Questions 1 and 2: Moving the discourse from the communicative to the coordinative sphere |
| 2. How does the diversity and volume of actors and institutions contribute to complexity? | A tiered service delivery model | Consultation with multiple levels and types of interest, and within context of concurrent disruption and uncertainty | Question 2 and 3: The agents of change – who they are and how they convey the ideas |
| 3. How observable is the dynamic of change? | Developing a Chronic Disease Strategy | Implementation and the iterative and practical development of the policy ideas | Questions 1 and 3: How and where the ideas emerge and the observation of the interactive processes of a developing discourse |

Figure 32 Structure of the analysis

The analysis within the case study chapters observed policy deliberation, as it happened within a defined period of time in Tasmania, in developing and implementing the health plan. The actions of key actors and actor groups were observed through the documented communication of meeting minutes and briefing papers, together with public consultation papers and records of responses, submissions, and Hansard records. This chapter takes the discussion forward to examine the barriers and enablers within the case study material that impacted on the development of new policy ideas, and to connect this with the challenges to health policy change identified in Chapter 1 and the literature review of Chapter 2 that focussed on the role of institutions, actors and the dynamics of change. There is particular interest in whether the dynamics of change itself are observable and, if so, what are the features and can they be articulated? The final part of this chapter considers whether there are observations about the limitations and potential utility of DI as a theoretical lens for this and further study, including the potential to develop a methodology.

The first case chapter (Chapter four) drew on documented material from the initial developmental period, from 2005 to early 2007, to focus on the processes of discourse and engagement with the shortfalls in primary health services through to the inclusion of a primary health policy focus in the Tasmania Health Plan. The case material was selected to reveal the features of getting onto the policy agenda through briefing papers and notes for internal DHHS meetings or the health minister that established the case for investment in the reform of primary health services, and for a PHSP. The rationale for the need to develop primary and community health policy and practice was not an isolated concern in Tasmania, but part of a challenge that faced other parts of Australia and the world (and still

does). This chapter drew out the different methods and approaches that the relevant actors and actor groups within the DHHS took to raising the issues, and the ways that they were successful in getting them listened to. These observations extend within the central bureaucracy of the internal organisations of DHHS and, in presentation of the arguments in various ways to the State Government, through the health minister. Ideas are not stable and have their greatest influence at times of uncertainty and change (Cartenson, 2011, p596), and this may be some of the explanation for the PHSP getting on to the agenda in Tasmania. Within a broader population change of rural decline and an ageing workforce, the primary and community based health services in Tasmania were increasingly struggling to maintain services and staff (DHHS, 2005c). Providing a potential explanation for the establishment of the case for a PHSP provided the opportunity to explore the boundaries between the coordinative and communicative sphere and the approaches that were taken to establish the discourse that would gain traction publically from within the coordinative sphere.

The second case study (Chapter five) explored the early stages of implementation during the rest of 2007 and over the 2008 and 2009 period, with the focus on how the ideas for new service models were developed and conveyed. The communication processes and the complex environment with multiple actors, actor groups and institutions, many of which were inside the DHHS, were observed. The process and dynamics of engagement were considered and the ways that ideas and concepts were conveyed and accepted within the context of constant uncertainty, diverse interests and differences in capacity, and power for the relevant actors and institutions. The establishment of a tiered service delivery model was an intentional system change to delineate service capabilities and make it easier for people to transition between levels of care. These concepts were easy for the community to understand, but less so for the health professionals who were more likely to be constrained by their professional interests and maintaining the status quo (Bates, 2000). This second case study chapter identified the key policy actors leading the implementation process and the complex policy environment that they needed to navigate, through formal and informal consultation processes. The chapter reviewed the primary data responses from the range of different actor and institutional perspectives and identified some differences in the perceptions and responses to the new policy ideas of the PHSP. This was happening at the same time that there were several restructures at the most senior levels of the DHHS, including the key actors involved in the implementation of the THP. The rationale for including analysis of the restructuring activity was to assist in understanding where the confusion that was expressed by some actors and actor groups was likely to have emerged from. It may have occurred because of resistance to change based on professional or other interests, a lack of understanding of the THP and the intended new service delivery models, or uncertainty with the structures of leadership or a combination of all of these factors.

In the methodology (Chapter 3, section 3.5) the key internal actors and actor groups within the DHHS were introduced, describing their relationship to the THP and the relevance to each of the case study chapters. There is an additional breadth and depth of explanation of understanding the field of actors and institutions that the implementation group engaged

with. This is further developed in the second case study (Chapter five), in which the consultation processes that engaged understanding and developed the discourse for a new model of service delivery. A simple stakeholder map (Figure 15) summarised the whole field in which the new tiered service delivery model was being introduced, and then a matrix of the specific groups directly impacted by the new approach (Figure 16). The actors, the institutional groups and their various responses to, and engagement with the new model of service delivery are described in detail. Figure 17 identified each actor and institutional group and defined the respective relationship to the DHHS and the THP, and the relevance of the proposed new service delivery model to their service or policy area. The final column in Figure 17 illustrated the complexity of the environment by identifying the particular issues of legitimacy or acceptability of the proposed model to each of the actors and institutions, very few of whom were neutral in their views.

The third case study in Chapter 6 examined the development of the chronic diseases strategy which emerged as a requirement once the implementation of some of the initiatives, policies and projects under the PHSP had begun. Similarly to the first case study, this chapter provided the opportunity to explore how and where the ideas emerged particularly focused on the interactions within the coordinative sphere. The material was selected to reveal the iterative processes of developing a discourse through multiple methods of communication that included option and background papers, information and consultation workshops, newsletters, fact sheets and a managed network. With the focus on a single area of sub-policy, the dynamic processes of change are visible through the detailed deliberation between the policy actors and their respective institutions, and the balancing of this with the feedback from individual consumers and health care professionals as well as community sector organisations. There were multiple re-drafts that nuanced words and phrases, or negotiated the positioning of the more substantial concepts and prioritisation of particular strategies, with the intention of achieving an acceptable policy outcome. This is, in part, another example of what Schmidt would argue is the consistency between DI and the constructivist interpretive approach. DI can go beyond the other theories of institutionalism and, for example, take the cultural context of social institutionalism and overlay the context of 'meaning' (Schmidt, 2006, p8). The key actors that formed the PHSP leadership group identified in Chapter 3 Figure 7 were deliberately influencing the other actors and institutions in order to pursue an ideational path that is consistent with Schmidt's articulation, as well as argued by scholars such as Campbell (2004) and Blyth (2002) who said that ideas are particularly useful in times of uncertainty in order to convey meaning.

The following three sections of the discussion will take each of the core research questions in turn to further explore how the dynamic interaction between actors and institutions, and the discourses of policymaking and change, are analysed using DI as the theoretical lens to observe the dynamics of health policy change in practice.

7.1 How are policy discourses constructed in the coordinative sphere?

The first case study starts at September 2005 and covered the period up to and including the initial political agreement to put the PHSP on the agenda for the THP in July 2006 through to the launch of the plan in May 2007 and the early implementation planning until late 2007. The DI lens provided the perspective to analyse this initial agenda setting process with a focus on the boundary between the internal deliberations within DHHS and Ministerial briefings. It is useful in understanding the processes of political and public persuasion that were required to ensure that a primary health policy focus was perceived as important enough to be included in the THP. These are referred to as the coordinative and communicative spheres, respectively, in the DI literature (Schmidt, 2008b; Schmidt, 2008c; Schmidt, 2008a; Schmidt, 2009). An example of this in the case material includes the extract (in Chapter 4, Section 1) from the internal briefing note about the changes that were occurring within the then Division of Community Population and Rural Health in DHHS, that stated:

[...] an incremental approach with many of these [systematic processes to achieve statewide consistency] having been done quietly with staff participation and without creating a high degree of public or industrial awareness (DHHS, 2006a).

It was anticipated that the case material selected for Chapter 4 would provide the opportunity to observe the development of the legitimisation of the ideas within the relevant institutions once the approval to go ahead had been given by the Minister for Health. The coordinative sphere is further observed in the ways these actors shared their ideas and evidence from policy networks aligned with Sabatier's advocacy coalition framework (Sabatier & Jenkins-Smith, 1993), to draw into the internal briefings to the incoming government (DHHS, 2006a) strengthened by, for example, the Richardson Report (Richardson, 2004). The actor group leading the PHSP development (see Chapter 6 for the development of the chronic disease strategy) made connections in other parts of Australia and internationally, in order to broaden the policy planning agenda and the development of the discourse to include the understanding of a need for primary health reform. DI is the distinct "fourth pillar" (Schmidt, 2006) from the other theories of institutionalism in its explanation of the actor behaviours within the context of institutions in the consideration of change. The analysis can be interpreted in a number of ways, and this discussion considers the case material in Chapter 6 as well as that of Chapter 4, where the detailed deliberations were more visible between the DHHS actor groups in the coordinative sphere. Schmidt argues (Schmidt, 2006, p5), that the ideas within discursive interactions "may enable actors to overcome constraints that the explanations in terms of interests, path dependence, and/or culture present as overwhelming impediments to action." There was an initial resistance to getting the PHSP onto the agenda, and then the detailed processes of resistance and constraint are evident in the development of the chronic disease strategy in Chapter 6.

The key actors in Tasmania had agency, and they used it in context when the combination of opportunities were available to them. For example, there were various health care plans that focused on primary health reform in the UK, Canada and in many of the Australian jurisdictions (referred to in Chapter 1), each with the intentional focus of reducing the burden of chronic conditions. These were reviewed and discussed locally, and briefings prepared to highlight the relevance or differences for the potential implementation in Tasmania, and referred to in the PHSP as follows:

While other States and Territories are experiencing similar issues, Tasmania's health is deteriorating at a rate worse than other States. In response, this reform program represents the first time that a jurisdiction has responded in a comprehensive and statewide way covering both hospital and community programs and services.
(DHHS, 2007h, p 11)

The Secretary, who had relocated from the UK in 2007, reinforced the linkages internationally to the Tasmanian opportunities for a primary health focus by stating: "In Australia we're on a bold journey, but thanks to Tasmania's Health Plan we know where we're going and are getting better all the time in measuring the progress we are making" (DHHS, 2009c). Health policy change has been occurring over decades, but there are more explanations of the lack of change than there are of the dynamics of the changes that have occurred. A useful distinction of DI is that the explanation of change is perceived as occurring over time and requiring the processes of agency within institutions that reflect and reframe the narrative endogenously, rather than caused through external forces or occurrences. This is the coordinative process, and the case material shows how this is shared between the senior policy leaders and the elected members, and changed and reshaped to meet the political need for a public narrative that would be supported and endorsed.

There was an 'ideational dimension' that marked out a new health policy paradigm in Tasmania that something different could – and should – be done. A narrative explanation of the process of the THP implementation was provided as a submission for an award to the Australian Institute of Public Management in 2009, and, in this, a reflection by senior policymakers stated:

Tasmania faces particular challenges [in comparison with the universal challenges of ageing and chronic conditions], and has a clear mismatch between its current services and the needs of the community. Tasmania's Health Plan will position the health system to meet these challenges now and into the future, ensuring services will be: accessible, as close as possible to where people live, delivered safely and effectively, client- and family-focused, integrated through service coordination and provider partnerships, and designed for sustainability. (AIPM submission 2009)

Schmidt describes this as requiring the combination of the internal consistency with that of the philosophical changes in policy thinking that would be visible in a more public dialogue.

There had been a public dialogue through consecutive reports in Tasmania that proposed rationalisation and better linkages between services. It was the Richardson Report (Richardson, 2004) that captured attention, perhaps coinciding with the timing of and provided a case for the support of a 'strong primary sector'. The Tasmania Health Plan was designed to develop better integration of the provision of health care across the range of services, agencies and regions as described in the extract from the AIPM submission.

The development of the concepts and ideas for policy options was important, but may not have been enough to gain the necessary legitimacy to establish the case for including a primary health focus to the agenda for a health plan. Schmidt argues that DI moves beyond the confines of institutionalist thinking to provide an opportunity to consider what ideas or discourse are more broadly common, and is therefore less contingent on path dependency, or cultural explanations such as that of the other institutionalist theories. Change can occur, according to Schmidt, in the juxtaposition of ideas and discourse with the political and community will. This is similar to the ideational analysis that Parsons (2001) describes in claiming causal relationships as the legitimacy for certain actions. Kingdon's (2003) three streams approach that suggests the 'window' of opportunity for policy change, is perhaps the most obvious analogy. The DI lens links the streams to ideational processes and the boundary between the coordinative and communicative sphere is that of the political framing in order to legitimise particular decisions.

There was evidence of the need to change toward primary health policy that impacted on Tasmania and was concurrent with approaches nationally and internationally (McGinnis et al., 2002; Bohinc, 2008; Richardson, 2005; Starfield, 1994; Eagar, 2008). For example, nationally on the 10th of February 2006 the Council of Australian Governments (COAG) announced the Australian Better Health Initiative (ABHI) that committed each of the jurisdictions, including the Tasmanian Government, to finding matching funding to establish programs and services for reducing the risk factors for chronic disease. At the same time in the UK in January 2006 the NHS White Paper "Our Health, Our Care, Our Say" was launched and called for a fundamental shift toward integrated services provided in local communities (Kings Fund, 2006). The UK was planning to introduce new 'closer to home' demonstration sites and to establish 'local triggers' to increase 'primary and preventive' health activity.

When the new State Minister for Health and Human Services, the Hon. Lara Giddings, was appointed in 2006 she was already committed to a health reform agenda. The opportunity for the leadership was to make the Minister, and through her the Cabinet, receptive to a policy narrative that would make an urgent case for the investment of resources to reforming beyond the institutional boundaries of hospital and clinical services. The combination of approaches to communication at the boundaries between the coordinative and communicative sphere was evident in the case material, particularly through the preparation and provision of briefings as the Minister took office (see Chapter 4 section 4.1.1).

Meanwhile, in the communicative sphere, there was still a long road to navigate for the potential legitimisation of these broader perspectives of health. The healthy public policy described in Chapter 1, has gained limited substantive traction despite the strength for evidence for the impacts of social, environmental and economic factors on health outcomes. The Human Development Report in 2003 (WHO, 2003) found that the movement toward primary care had been generally very narrowly focused, and that despite this, primary health care services remain inadequately organised, under staffed and poorly funded. In Tasmania, the government had indicated that the leverage for action to develop primary and community services was powerful when it was stated that doing nothing would lead to potentially catastrophic consequences. The process of primary health policy is inevitably redistributive over time, as Figure 3 demonstrated in Chapter 1, adapted from Keleher (2004), in which the interventions move from the lifestyle and behavioural focus, through a social policy acknowledgement, to structural redistribution of resources. These boundaries between the public dialogue and the internal policy deliberations had to be broached in order to make the case for change that would be acceptable to the community. The reframing of what was, in real terms, a slow change, was portrayed as a necessity when seen together with the dramatic commentary about the 'epidemic' of chronic disease in Tasmania. The Minister bridged the communicative sphere and described the need for change in the plan as:

The impetus for reform comes from a number of quarters simultaneously. At the base is an increasingly ageing population coupled with an epidemic of chronic disease. This epidemic will continue to worsen while the health risk factors for chronic disease in the community remain high. In other words, Tasmanians are in the midst of a chronic disease epidemic that must be dealt with now and we must also deal with the causes if we are to stem the tide in the future.

At the same time there are escalating costs in our hospitals, problems in recruitment and retention of health professionals and a clear mismatch between current services and the changing needs of the community. This means Tasmania has a system that is unsustainable and not able to respond to the challenges it faces. (DHHS, 2007h, p12)

This is the technique that Stone identifies as the use of a synecdoche (Stone, 2002, p162) to provide a symbolic representation of the problem, which she summarises as: "a small part of a policy problem ... used to represent the whole – for example a horror story". While it may have been a more convincing horror story to share some of the clinical risks involved with the rural facilities, this was not seen as appropriate as the communities are small and the narrative would become too personally identifiable. Instead, the driving factors behind the PHSP were articulated as being concerned for long term sustainability, and the external emphasis it was given was that of having to change before the breaking point was reached.

The positive story within the coordinative sphere was that of building the partnerships and collaborations between health and social care sectors, and with the education system, to

improve health as well as to improve connections for people living with ill health, and to build a workforce for the future capable of managing the future models of care that would be required to manage long term and chronic conditions. This was the intentional policy purpose, and the new paradigm for a comprehensive primary health approach that is most fundamentally articulated in the Alma-Ata declaration (WHO, 1978) that referred to primary health as the approach that extends outside of health care to the social and economic developmental needs of the community.

The narrative articulated the need for better efficiency and effectiveness of available resources, analogous to that used by Stone (2002). The competing realities of the political, technical and values-based reasoning were also identified by Lin and Gibson (Lin, 2003) who suggested that simultaneous truths can sit together depending on the perspectives of the actors and their relative power in the context. The senior policymakers in Tasmania were willing to work with the purposeful intent of the fundamental policy change; however, it needed to be described in the public domain. The reason for traction in gaining a commitment to getting on to the policy agenda in 2006 is, in part, attributable to timing. There was a combination locally of the Richardson report calling for a strong primary sector and the sustainability issues with rural inpatient facilities. This came at the same time as there was national and international policy discussion about strengthening primary and preventive health activity (DoHA, 2006, HM Government, 2006). Whatever the reasoning, it was a way of presenting the idea that proved successful with Cabinet. In DI terms, the legitimacy of the policy narrative had been realised with the conceptual construction of the possibility for a paradigm change. In the spring of 2006 the DHHS and the (then) Community Population and Rural Health Services leadership group (ComET) got to work on initiating the research and interest for a plan through its internal and external stakeholders.

A further and particular process of the construction of a new narrative is evident in the third case set out in Chapter 6, which focused on the emergence of the need for a chronic disease strategy that had not been identified at the start of the planning for implementation of the health plan. Initially it was identified as a program stream – “health centres against chronic disease”, and then it was changed to a program of work – “preventing and managing chronic disease”, and several separate projects. However, as implementation of the THP progressed, the lack of a common policy definition for chronic disease became problematic. Eighteen months after the launch of the plan, the internal decision was made to establish a chronic disease strategy to bring the thinking together overall. Differences emerged as the projects began to be articulated and the different sub-institutional groups within the DHHS began to identify their objectives for reducing chronic diseases. The population health approach, for example, focussed on the assumption of common risk factors such as physical activity and nutrition, whereas the primary health services targeted the development of care pathways for individuals with specific chronic conditions. What was revealed were different policy assumptions, each of which were likely to be associated with institutional or professional interest or bias. The further analysis of the construction of the discourse was made almost entirely within the internal sub-institutional groups within the coordinative sphere. The key leadership group of actors that lead the chronic disease

strategy development were observed continuously reviewing and responding to multiple strategies and approaches at a relatively small scale of deliberation. Each of these strategies or changes would, in turn, contribute to the greater objective that was managed within the epistemic core actor groups. This small number of actors who formed the key leadership group for the PHSP were focussed on the overall change toward a primary health policy approach. In the DI literature, they were the 'sentient agents', utilising whichever instruments that could be most opportunistically leveraged at a particular time toward the intended result.

DI scholars tend to divide between whether policy change occurs as a result of a paradigm shift in thinking or discourse, or because of more incremental changes in ideas over time. The inclusion of a primary health policy focus to the THP seems to point to the combination of timing and incremental changes in health policy ideas that found an open door with the combination of policy activity and the change of government in April 2006. Similarly, the development of the chronic disease strategy and the ways in which this was shaped and negotiated internally within the DHHS suggests that the ideational change was contingent on timing and opportunity. The inclusion of the primary health approach in the Tasmania Health Plan can be viewed as a factor in the longer term changes that were occurring in health policy thinking, in Australia and internationally.

In her 2011 article on the dynamics of policy transformation (Schmidt, 2011c), Schmidt suggests that there are a number of possible explanations for the dynamics of change and the circumstances that enable it to occur, including that there is no objective explanation. It could be argued that the agents of change, in this case the senior leadership group in CPRH within the DHHS, constructively used the change of government as the opportunity to frame and legitimise the new policy discourse for a broader health policy focus. Alternatively the window of opportunity (to use the Kingdon analogy) (Kingdon, 2003) opened the opportunity for a change in policy or direction, regardless of whether the ideas were substantively new. The chronic disease strategy case in Chapter 6 was also transformative, but on a smaller scale. The Kingdon explanation is a satisfactory one because there was an alignment between the issues and the political environment, and the policy development was part of a larger ideational change in the policy discourse that the same actors were part of and that was occurring concurrently elsewhere in Australia and internationally. The DI lens is particularly helpful because it extends both of these premises to encompass the endogenous adaptation and reframing of the narratives that impact on the changes that did occur (see Figure 6 in Chapter 2).

7.2 How does the diversity and volume of actors and institutions contribute to complexity?

In Chapter 3 the key internal DHHS actors and institutions relevant to the THP were identified (see Figure 7, section 3.5). There were multiple actors and sub-institutions within the DHHS, including the Executive and the overall leadership group for the THP and the PHSP. In addition to this there were particular executive groups that had a significant stake

in the THP, including mental health, alcohol and drug services, oral health, population health, palliative care and primary health services. There were other sub-institutions that were not within the immediate domain of the DHHS, though nonetheless they were managed by them. These included the rural in-patient services, community health centres and community nursing and allied health services that were located in rural and regional facilities across Tasmania. Each of these groups of actors and sub-institutions had a stake in the THP to an extent, and some were particularly concerned about the impacts of changes. Chapter 5 of the case study chapters analysed the early phase of implementation and expanded the range of actors, actor networks and other institutions involved by identifying the perspectives that each would have held in response to the proposed change to new service delivery models. The question raised is how and whether the volume and diversity of the actors and institutions involved contributed to the complexity of the processes.

Setting the context to establish a new services model is a feature of the coordinative function of DI. In the case material, particularly the second case set out in Chapter 5 that examined the proposed new tiered services model, the leading policy actors would be described as 'sentient' (Schmidt, 2010e; Schmidt, 2011b) in the DI literature. The policy actors were observed laying the foundations for the new expanded health policy by describing it and informing the other actors, particularly the staff in the institutions that were likely to need to change, on how the new service delivery models would work in practice. This was developed through consultation and discussion, sharing newsletters and progress papers and by sharing examples of similar practice change in other places in Australia and internationally.

This layering of the ideas for a new paradigm can be observed, but is it observable as Historical Institutionalism would suggest, by adding new elements to otherwise stable institutional frameworks? In the 2008 presentation to the American Political Science Association Meeting, Schmidt and Monnet (Schmidt, 2008c, p6) propose that "change itself can be seen to come about through a variety of processes resulting from the continuous interaction between 'rule-makers' and 'rule-takers' and producing new interpretations of the rules". The characteristic in the observed behaviour to state a new policy paradigm through the new service delivery model was a component of the key actors' motivations and their interests in establishing policy change. The key leadership group of actors within DHHS in Tasmania laid out the ideas for the proposed new service model, and established the foundations for change as a step in the intended direction. It is evident that the key actors had philosophical and intellectual interest in a macro-policy change. There was evidence of literature reviews and references to concurrent or earlier policies that had been drawn from active participation in networks that extended nationally and, in some cases, internationally. They actively mapped out new ways to solve the complicated and seemingly intractable policy challenges of reducing the burden and impacts of chronic disease in Tasmania, congruent with the coordinative sphere activity identified by Schmidt.

There had been a strong emphasis on partnerships and collaboration in each of the work streams from the outset of implementation of the PHSP, as well as between different institutional parts of health care services, and between services and the central agency support staff. Some of the key factors that assisted the early planning for implementation were based on the relationships within the DHHS that had been established over time. These established relationships became more important as the challenges of conflict in the communication and understanding of the proposed changes unfolded. Misunderstandings and strained communication is an inevitable feature of any change and there were conflicts between organisations in DHHS, between professional groups, with other sectors, with the Tasmanian community more broadly, and within parliament. However, the constructive development of the ideas and their implementation kept going, and there was targeted investment in setting up partnership initiatives that were intended to be proof of concept or pilots for improved models of care and service. There was planning toward a health promotion framework and a self-management framework. Implementation of each of these included workforce training and development for staff and communities to put them into practice, together with the recruitment of new health promotion officers; and pilot projects within individual services and centres (DHHS, 2007b; DHHS, 2007c).

In 1998 Rhodes analysed the closed networks relative to the British Government at that time, noting the influence of 'policy communities' which he described as having "stability of relationships, continuity of a highly restrictive membership, vertical interdependence based on shared service delivery, responsibility and insulation from other networks and invariability from the general public" (Rhodes, 1998: 78). A review of the contribution of primary and community health services in Australia by UNSW (McDonald, 2004) identified common organisational elements that need to be addressed for the achievement of optimal primary health networks as follows:

- A well trained workforce with access to ongoing professional development and support to develop and implement new skills and ways of working
- Visible leadership to bring about cultural changes
- Addressing the challenges associated with diminishing workforce and increasing workloads in the development of models to strengthen multidisciplinary care.

The PHSP was particularly oriented to meet the last of these three elements, but the workforce was probably least developed. While there was a visible leadership within the management of the services, this was destabilised by the political and head of DHHS executive leadership interventions that were introduced without enough explanation or context for the frontline workforce to integrate into their practice. For example, the introduction of a 'matrix management' organisational structure for the DHHS leadership executive was directly at odds with the structure of the area services and locally based service organisation models, and fundamentally contradictory to the professional norms for health care staff who were familiar with hierarchy and professional accountability.

As long ago as 1978, Hanf and Scharpf (1978) realised the need to “intervene in the existing structure of interrelations in order to promote the interactions appropriate for mobilising a concerted or coordinated effect consistent with the objective interdependencies of the problem situation”. And before that, Geoffrey Vickers (1970, p128) spoke of the challenges in interpersonal relations that make it difficult to distinguish from the misunderstandings and abuses that come from the “experiencing of relations that is, or is expected to be, satisfying in itself”. It may have been possible to have made more changes during the active implementation phase than was actually achieved, given the existing relationships between the senior policymakers and the frontline staff. See, for example, the briefing note in Chapter 4 that referred to the changes within CPRH (in DHHS) over time. However, the confusion caused by the nature and the pace of change in structure at the top of the DHHS leadership executive made it challenging to actively respect and further develop the existing relationships. This, together with the lack of community confidence at the local level, may have contributed to the lack of practice change at the more fundamental level, though it is not possible to test this hypothesis to know whether or not it is true.

The DI scholars, and Schmidt in particular (Schmidt, 2011c; Schmidt, 2006), suggest that the DI analytical framework enables the identification and description of the interactions between actors and institutions that are beyond the new institutionalism explanations of interests or the ‘path dependence’ of HI as the impediments to taking action. DI complements the other theories of new institutionalism by lending additional insight to the dynamics of change, and in the understanding of context that is contingent to the actors and the ideas in relation to, but not dependent on, the institutions they belong to. The internal institutional relationships in the context of the implementation of the THP were characterised by the norms and identities of the key actors that constituted the culture of the Tasmanian DHHS, and the tipping point for the traction that was gained as the ideas were conceptualised and given meaning despite, and as well as, the structural and organisational changes that occurred.

However, while this explanation refers to the active sub-institutional leadership group within DHHS, not all of the institutional relationships were the same, and some would conform more to the analysis of the more static ideational structures. The rural communities surrounding one particular inpatient rural facility, for example, were undermined by the proposed structural changes in the proposed tiered services model. The staff and community supporting them made a break with the previous historical path that signified deterioration rather than a development of the relationships between professional groups or state institutions at that time. The Historical Institutionalism analysis of the responses to change in the particular rural community with a proposed change to an in-patient facility was indicative of other small rural facilities, not only in Tasmania but in other parts of Australia. For example, in 2007 in South Australia there was an announcement to review the rural health program because the local inpatient services were not sustainable clinically or financially. The staff at the facility in rural Tasmania had previously acknowledged the need for change during the development phase of the THP. However, as that potential

impact of change became evident for their own facility, they preferenced their community and local relationships over that of the THP leadership and the conflict erupted.

The network governance literature introduces the notion of the 'network manager', a function that provides coordination, communication, conflict management, brokerage and linkages between the different sets of interest, recognising that this is necessary in an interdependent world for action to be achieved. The need for network management was recognised as an intentional requirement for the positions of the Primary Health Coordinators and the Health Promotion Officers at the local level. In the first two years of the implementation, this explicit capability was recognised and supported in a more strategic networking position that the author of this research held as Director Community Health Services Reform in December 2007. This position later became Director of Statewide Service Development when the title and responsibilities of the Deputy Secretary for Community Health changed to that of Deputy Secretary System Development.

Klijn (2005) describes the network manager role as requiring the acknowledgement of the following characteristics:

- Power and authority – no hierarchal control of the process, but power and authority are negotiated, exerted through influencing others, and the respect and power that is gained and lost at different times and through different processes
- Goal structures – no single unified goal, but different actors will have different goals, and some additional goals will emerge during processes
- Management role – more of a process manager, facilitator and mediator in the inter-organisational space
- Management activities – traditionally described as planning, organising and providing the leadership to follow things through. The network management equivalents are described as 'goal finding, perception accommodation and coordination'.

Policy is better when it listens to local knowledge and interpretation. Numerical analysis on its own is not enough and the understanding of a policy's consequences for the people it will affect requires 'local knowledge' (Yanow, 2000) and the practical understanding of circumstances as a result of lived experience. Examples include an article by Schmidt in 1993 (Schmidt, 1993) in which she describes the collapse of a Washington bridge after the local knowledge about the requirements for using a more dense cement to allow for local conditions was provided by local site engineers and ignored by policymakers because of its greater cost.

The significance of contextualised knowledge in the dynamics of institutional change is a point of distinction between DI, with its emphasis on observation of the interaction of the ideas and other versions of new institutionalism. DI scholars tend to emphasise the people

who are at the centre of the construction of new policy and the ideas that form the basis for action and legitimacy, and this is expanded by Schmidt in “give peace a chance” (Schmidt, 2006). In the case of the establishment of the ideas for new service models in Tasmania there was a combination of coordinative activity that has been analysed. Firstly, there were closely connected actors, mostly within the leadership group for the THP and some of whom had been deliberately appointed (such as the author) who actively deliberated and progressed the concepts and the options for practical implementation by the key actor groups and organisations within and between the local policy context. Then there was a subset of actors who were more loosely connected through the ideational concepts of a social model of health and a broader consideration of the underlying determinants of health and how these ideas could be successfully incorporated into health policy. These are identified in Chapter 3 (see section 3.5, Figure 7).

There were multiple actor networks in Tasmania and, although the most productive developmental discussions were between actors with an interest in the health policy implementation, the most active contested views were expressed by those whose work practice was most likely to change as a consequence. There were a number of actors for whom there was a deeper intellectual and ideological interest, who were engaged with the process of legitimising the case for a focus on primary health approaches to health policy because of the belief that it would better serve the needs of the Tasmanian population. Some of these actors were active within professional associations and policy networks for public health, health promotion, or primary health. The case material that included extracts from email exchanges revealed that there were underlying principles that tie back to the historic roots of primary health, at the same time as developing them for the location-specific application within the context of the health plan in Tasmania.

7.3 How observable is the dynamic of change?

The processes of fundamental health policy change have taken decades and while the concepts of healthy public policy and ‘health in all’ policy are acknowledged as being likely to have traction in improving the complex causative issues of ill health, such as obesity, there is patchy and inconsistent evidence of implementation in Australia. The PHSP in Tasmania was intentionally aimed at making fundamental health policy change and the observation of this short period of time in Tasmania is usefully analysed through the theoretical lens of DI.

The dynamics of what occurred lie at the juxtaposition of the intentional and evidence-based change that the ‘sentient’ agents – the policymakers – were aiming for as outcomes, with the political election cycles that require short term measures of achievement.

In the early processes of consultation, during the first six months between October 2006 and April 2007, 146 written submissions were received and 1052 people attended local consultative meetings. Findings confirmed the existing perception that policymakers had

articulated, that there was significant fragmentation and a lack of consistency within the primary and community health sectors, and poor connections between mental health, disability and housing services, and between primary and acute services. Historically based arrangements in staffing structures, budgets and the location of services, along with inconsistent referral processes, were leaving some patients and clients with limited or no service in some parts of the state, where other areas were relatively over-served. There was very little evidence of community input or involvement in service development or needs assessment. Whilst this picture was relatively bleak, there was a strong commitment and alliance made during this process between the professions, trades unions, and rural organisations. The hope that was generated for service improvement and response to the crisis of chronic disease was seen positively, especially with the personal gains that could be made from people being able to take greater control of their own lives and health.

There is, however, a significant difference between the rhetoric and the vision for change, and the actual dynamics of change itself. As the introductory chapter described, chronic conditions have multiple causes and trajectories, and require the realisation of permeable boundaries between institutions, care services, and health care professions. There is an inevitable impact on structure, governance, speciality, referral processes, and the understanding of the self-management implications for individuals. Conflicts quickly arise when policy is implemented, because the translation from the big picture concepts to the micro- level of professional decision-making is inevitably complicated.

DI provides the means to understand how the ideas are both constructed and then considered and developed, as well as to acknowledge the role that institutions play, and how each of these factors is mediated through discourse at a specific historical juncture. In particular, the explanation of change occurs through background ideational construct and foreground discursive capabilities (Schmidt 2010b). In the early developmental phase of the PHSP this process is observable. For example, the development of the initial model for primary health partnerships (see Figure 15, Chapter 4) described the need to acknowledge and strengthen the relationships between service providers and citizens locally, as well as the structural partnerships and collaborations with local government and community sector organisations. The ideational thinking within the coordinative sphere was intended to optimise the primary and community health services. This was seen as directly aligned with the international policy thinking about the outcome benefits in giving people greater control and influence in needs assessment and service planning and development. However, the context was also one in which a national primary health policy consistency had not yet been achieved since first being articulated strongly in the final report of the Better Health Initiative in 1987.

Figure 6 (the four new institutionalisms), in Chapter 2, describes the differences between the theories. As they were each initially constructed, the new institutionalism theories were more focused on why change doesn't occur rather than why it does, and each has a different perspective on the binds and constraints within institutions that maintain the stasis. Change was explained as occurring because of exogenous shock of political, legislative or

economic change. The processes of returning to stasis were then observable through the path dependent historical practices, the alignment of new norms or the calculated ascription of power and interests. As the emergence of a new ideational focus in institutionalism started, there was a reconsideration of the explanation of change within all of the theories of institutionalism. Historical Institutionalism accounts for change as occurring incrementally with 'layering', 'policy drift' or 'conversion', each of which has a slightly different means of creating new practices and positioning. These accounts of change through the lens of Historical Institutionalism, together with Rational Choice Institutionalism, make particular sense of the professional bureaucracy if the analysis was limited to hospitals or particular health care settings. However, the analysis of the PHSP in Tasmania sits in the context of a complex multi-sectoral environment with a diverse range of actors and institutions. The DI lens that views the endogenous construction of change through the reframing and recasting of narrative, using both the variety of formal and informal coordinative networks and communicative action, is more conducive to explaining the potential dynamics of change. This is particularly so in this case analysis that seeks to observe and explain the adoption of new ideas across agencies and the gaining of normative commitment to redistributive health policy approaches. The ideas are adopted beyond the traditional interest group politics that include the conflicts over resources in the dominant health policy context.

In order to better understand some of the subtle processes of change that were occurring through the development of the ideas and their implementation, it is useful to consider the work of another scholar whose work is related to DI. Colin Hay uses the term 'constructive institutionalism' to mean more or less the same as the DI term that has been coined by Schmidt, and describes a distinctive opportunity to make sense of the institutional adaptation and evolution that occurs through the interaction of actors (Hay, 2008, p6). He suggests that actors are strategic in their focus on making progress with their ideas, even within a context that may be complex and contingent. This, Hay argues, demonstrates a proximity to the role actors play in international relations theory, by perceiving what may work in a particular circumstance and balancing the construction of the ideas to the context in which they will have to be realised. This is an important point which is relevant to the construction of the ideas for a new service model for Tasmania's Health Plan, because it reveals that the actors and their ideas cannot be separated. This is distinct from rational choice, or Sociological Institutionalism, and their actions do not arise only from the institutional setting in which they are located.

At the heart of it, the observation is that the process of developing new service models is endogenous. The actors, and particularly the policy elites, have a commitment to enabling the discourse within and outside of their institutions, but they are working within a context (as the case study Chapter 5 particularly explains more fully) of an unstable and arguably dysfunctional institutional setting. This instability is the dominant health policy discourse discussed in Chapter 1, and referred to by Hacker (2004) as being more evidence for "reform without change and change without reform" in the USA. It was articulated strongly by Braithwaite (Braithwaite et al., 2005) as pervasive restructuring that lurches from centralisation to local control, with little or no evidence of there being any demonstrable

improvement in productivity or outcomes. The ideas for fundamental health policy change, however rigorously developed, are inevitably likely to be highly challenging to put into operation, given the broader policy setting. In Chapter 5, for example, there is a presentation of the material to establish a new tiered service delivery model which was integral to the implantation of the PHSP. There were existing local area networks of practitioners that were able to pick up and work with the new primary health partnerships, particularly in locations with local champions, existing capacity and capability, or a funding or service imperative to network locally.

Other parts of Tasmania, however, were slow to pick up the ideas, or more actively resistant to the proposed change. Some of the small rural communities were going to be directly impacted by changing from small hospital inpatient facilities to community health services. These communities were already in decline with population drift, and the proposed health policy changes came on top of the loss of businesses such as shops and hotels, and the capacity to maintain local social clubs and a voluntary fire and ambulance service. As the description in Chapter 4 indicates, the conceptual ideas were somewhat abstract, and institutions and actors got behind them as 'motherhood' ideas that seemed to be good for everyone. However, once there was progression from the early stages of implementation, expectations began to change, differences prevailed and the threshold of normative change created a push back to maintain the status quo. At the second stages of consultation in Tasmania there was an increase in the number and type of submission from individual citizens. They were notably from the areas impacted most directly, where people voiced their concerns about the perceived loss of services to their local communities. In one example, an alliance of individuals and organisations in the Central Highlands area bought a whole page in the regional newspaper, *The Mercury*, (*The Mercury Newspaper*, 2009). Titled 'The Black Hole', it showed a map of Tasmania with a big black circle covering the region, illustrative of what they saw as the State Government's intention of "wiping the region off the map with its intended health policy plans".

There is an observable dynamic in the early development of the implementation of the PHSP when the inconsistencies of language and approach internally within the respective parts of the DHHS started to emerge. For example, the development of a statewide health promotion policy was focused on system and population level change to prevent chronic disease. Concurrently, the capacity for the prevention of chronic disease within primary health services was focused on the development of accredited training programs for nurses to develop their skills in identifying and communicating lifestyle behaviour change opportunities with their patients. These examples highlight the different perspectives to develop policy to prevent chronic diseases, each of which are valid and dependent on the professional influence, the dominant actor network, and the institution or sub-institution responsible. It was possible to overcome this at the conceptual level by establishing a broader framework, in this case a Chronic Disease Strategy, within which each of the different approaches could fit. The intentional outcome was that "services are designed and delivered based on a common understanding, priorities and approach to the prevention and management of chronic disease".

There is evidence that some ideas took hold, and the slow, but probably inevitable, fundamental health policy change is occurring. However, as the first chapter explained, with a trend to stasis in all health policy, it is an optimistic position to state that the dynamic is observable. DI is demonstrably a method of revealing aspects of the discourse and processes that maintained stasis or enabled change relative to the networks of actors. It has been a useful lens for considering the actions of the various actors and actor groups, and the institutions identified described in the case material.

The analysis draws heavily from the scholarly theories that led to DI that include, but are not exclusive to, the institutionalism or new institutionalism theories. However, it was problematic to attribute evidence of change from the case material because of the combination of the contestability of the environment, including the public and political pressures, and the unintended consequences of changes that were occurring nationally and impacting locally.

7.4 The limits of discursive institutionalism

The theories of institutionalism are sometimes mixed in analysis by other scholars, and Schmidt acknowledges this (Schmidt, 2010b) in the European Political Science review. One of the distinctions of DI is that institutions are seen as less important than the ideas, and described by Schmidt as “internal ideational constructs”. The other institutional theories, and Historical Institutionalism in particular, have more recently, like DI, proposed that change is endogenous. This seems to be too mechanistic and potentially predictable, without giving enough weight, as DI does, to the critical thinking of ‘sentient agents’ who are consciously changing their institutions from the inside through deliberation, contestation, as well as consensus-building around ideas.

Schmidt suggests that these ‘sentient agents’ can use the historical rules and structures as background information and establish meaning within a context that may respond to junctures or reinterpret an institution. This is referred to as the ‘two-step institutionalist approach’ (Schmidt, 2006) in consideration of the differential impact of the European Union for which an HI analysis was insufficient. There is, Schmidt notes, a development of what may be seen as DI arising out of the tradition of Historical Institutionalism. Ideas that take hold endogenously, for example, and where they do not fit with the institutional structure, are potentially explained as a break with an historical path. The following extract from Chapter 2 Figure 7, is a reminder that Schmidt has also noted that each of the theories of institutionalism have endogenous explanations of change (Schmidt, 2010b). This had previously been one of the distinctive features of DI.

| Institutionalism theories | Rational Choice | Historical | Social | Discursive |
|---|---|--|--|--|
| <i>Recent innovations to explain change</i> | Endogenous ascription of interest shifts through RI political coalitions or HI self-reinforcing or self-undermining processes | Endogenous description of incremental change through layering, drift, conversion | Endogenous construction (merges with DI) | Endogenous construction through reframing, recasting collective memories and narratives through epistemic communities, advocacy coalitions, communicative action, deliberative democracy |

The distinction remains, arguably, that DI provides the additional explanation of the role of legitimising ideas as well as the persuasive discourse in the communicative sphere that enables the public acceptance of a policy direction. This ‘reframing’ and ‘recasting’ is different from the HI explanations of ‘layering’ or the ‘cultural change’ explanation of SI.

Schmidt concludes, however that DI does not explain change completely, because ‘stuff happens’ in terms of material and economic circumstance that result in events that are outside of people’s control. Changes occur without conscious or deliberate planning. Some policy actions have unintended consequences, by creating new practices as a result of ‘bricolage’ or by destroying old practices as a result of the displacement of previous mechanisms. (Thelen, 2004; Streeck and Thelen, 2005). These authors describe change as being more incremental and include the description such as ‘punctuated equilibrium’, or the ‘layering’ of new ways of operating, the ‘drift’ when there is a failure to otherwise act, or the ‘conversion’ with the adoption of new goals or the incorporation of new groups. In her 2012 paper for the Annual Meeting of the American Political Science Association, Schmidt finds these descriptions “elaborate”, but providing “little to explain why changes occur in the way that they do” (Schmidt, 2010c, p4).

Nikola (2011) finds DI provides an inadequate distinction about where and how discourse is developed within the definitions of coordinative and communicative spheres. However, this detailed consideration of the three years of health policy change in Tasmania has been able to reveal some of this distinction more clearly. The critique finds that there is a challenge to enumerating the types of actors that can be involved in coordinative discourse, however, this thesis has provided a detailed review of the types and interests and impacts of the different actors involved in Tasmania. Nikola (2011) argues that Schmidt does not elaborate on the distinctiveness of coordinative discourse vis-à-vis communicative discourse. “What is the nature of coordinative discourse and what are its characteristics are only a few of the questions that require answering if one wants to develop on the very important distinction between coordinative and communicative discourse?” This thesis has particularly focused

on the coordinative discourse, but it has also (in Chapter 5 for example) considered the boundary with the public and political discourse.

Bell (2011) finds that the challenges posed by Schmidt and Hay to explaining institutional change are generally somewhat “exaggerated”. The constructivists, Bell argues, having overly and perhaps misguidedly critiqued the HI view that it is too institutionally bound, run the risk of missing the importance of agency *and* institutions. Bell interprets Parsons (Bell 2010) as demonstrable of the overlap in thinking with HI in particular, that leaves the ideational and constructivist new institutionalism, such as DI, as more muddled than distinct.

A further feature of DI is that it provides the better explanation of change over time. Change, in the context of the questions of fundamental health policy change, is about both agency and structure, as Chapter 1 described. Structural accounts of policy usually at least imply deterministic behaviours by the agents, but they can, as Bell suggests (Bell, 2011,p16), include the broader political, economic or social environment. These structures, which include age distribution, or the relative power of difference within polity or networks, are shaped by agents themselves, and the patterns in relationships can, and likely will, change over time.

There is clearly some value and merit in the application of DI as a theoretical lens to this study about fundamental health policy change, and it does shed light on the processes of communication and development of ideas toward the dynamics of change within institutions in Tasmania. The empirical evidence reviewed through the case studies in this study was able, for the most part, to be explained through the theoretical lens of DI. Was it possible to find evidence of the ‘dynamic’ process of change that is the third key research question? Probably yes, at least in small part, but it is not all satisfactorily accounted for by DI, and doesn’t provide an adequate explanation of power and interests, or how and why one particular element of change occurs over another.

DI has not yet fully developed a methodology and it has not been significantly applied at this level of locality and granularity, and so there will be more to learn as other scholars explore and apply this approach further. One such study focused on the ideational approach to understanding the UK health care reforms was undertaken by authors at Birmingham University (Millar et al, 2013). They considered the communication of the ideas of health policy change within health care settings, and found that the more complex area of primary care was more difficult to observe than within hospital settings, where the actor and professional groups were more predictable and the policy more uniform in its implementation. A few years earlier, Harmer (2011) considered the ideational factors of global health policy change by reviewing policy documents and transcripts of speeches, together with interviewing some of the key international actors. That study categorised discourse into a series of indicators from the initial development of an argument through to the translation to accessible language for the public. However, it is not clear whether there

is a stronger reference in the interest-based accounts of Historical Institutionalism, and concludes that constructivism needs further exploration.

This study has found some evidence of emergent new norms in health policy thinking, but there is still a gap in explaining whether fundamental change in health policy practice has actually occurred. There is some evidence of incremental change, and some of the barriers are evident as well as the features that assisted deliberate processes to establish new practices and policy. Gradual change is more common and Mahoney and Thelan (2009) refer to its potential or transformation over time. Hall (1993) made the distinction between levels or orders of change and proposed that fundamental change in health policy would equate to a 'third order' of significance that would entail the change to a new set of values and principles. To be precise about the specific features is challenging and, in part, this could be attributable to the broad failure of the social sciences. There was a huge promise made by the combined disciplines of the social sciences that they would provide the evidence for change in the same way that the natural sciences had purportedly done in previous centuries. With so much of the detail of the analysis being subjective interpretation, it may be overly optimistic to make too strong a claim. Institutions are always incomplete, and the coalitions within and between them are always shifting with the circumstances of what they govern. However, this is a risk in the interpretation of the material because the author may have bias that influences the research choices and opportunities. And, conversely, one of the strengths of the thesis is the insider access, policy knowledge, and capability of the observations that are made.

Whatever was anticipated with the application of DI theory as a theoretical lens does it provide enough tangible insights for analysis? Should DI be further advanced and a methodology established? Does it help explain the future? DI, and the associated scholarly literature and thinking that provides the background to it, certainly contributes understanding and a political analysis for the consideration of broadening health policy. It also provides observation of the dynamics of ideational discourse in practice and the multiple discourses and forms of engagement within government that contribute to the complexity of making change happen in practice.

If DI develops further there are particular component parts that are missing such as the consideration of power and the influence and impact this has within institutions and among respective actors. Power is better accounted for in the organisation theory literature, and perhaps as more analysis is undertaken utilising DI as the theoretical lens there will be further consideration of its impact. It is possible that a further refinement of the DI theoretical model could incorporate an organisation theory account of power.

There are multiple sources of power and complexity that will work with and against each other – positively and negatively. Djelic & Sahlin-Anderson, for example emphasise the need to understand the formation of complex coalitions and multi-directional influences and conflicts (Djelic & Sahlin-Anderson, 2006). Meanwhile, Thelan (Hall & Thelen, 2009) suggests that the persistence of distributive policy can be better understood through

observing the mobilisation of agency, or lack of it, within institutions. New models, methods and approaches to public sector governance are required, and there is evidence of it emerging, but there is no single and clear definitional approach as yet. This could be because a new approach that takes account of fundamental health policy change needs to be responsive and adaptive in a complex environment in terms of communication and change.

What is needed are some other dimensions of governance that acknowledge and take account of the influences and impacts more broadly in society. Scott provided the opportunity to better understand the contestability of organisations and the respective competition and conflict within and between them (Scott, 1995), and the NI approaches, with DI in particular, have enabled the juxtaposition of structure and agency to be partly explained. But the ideational change that impacts more fundamentally on practice for the policy actor and practitioners who are working for this over decades requires a broader consideration of governance, noting the political opportunities and societal frames that shape the diffusion process. The capacity for change to occur depends on the capacity to continue to balance accountability and adaptation, with the key actors in government willing to frame and re-frame the issues and strategies as the opportunities present. I am left with the view that the scholarly thinking of complexity and some of the understanding of social movements in conjunction with DI could fill some of this void. More of this is explored in the concluding chapter that follows.

CHAPTER 8

8 Conclusion

This thesis has presented an account of the dynamics of health policy change, and the concluding chapter will consider the implications for institutional arrangements and public service governance in the context of fundamental health policy change. The research has provided insight into the dynamics of policy change and some of the features of veto or passive resistance by actors and organisations with vested interests or different dominant discourses that inhibit fundamental change from occurring. There is a better understanding of agency and the ways it was applied to deliberately advance change, together with the complex levels, volume and processes of communication of the ideas observed inside of government and between government, private and community based institutions. The focus of the case material has been between actor groups and institutions within government and there has been an explanation of the processes of deliberation and the circumstances in which ideas gain traction and changes occur.

A significant feature of the thesis has been that of the level of access to the breadth and depth of material documentation. This has provided a rich opportunity to view the detailed processes of policy making as it happens from inside of a state government health department. The thesis contribution offers new understanding of the processes involved with the deliberate and intentional pursuit of changes in health policy and how this is reflected in the day to day communication between actors and groups and between the public service institutions and the elected members of government. In particular, this research has provided insight into understanding the complexity of health policy beyond the heuristic explanations of process and structure, as well as to the application of DI as a theoretical lens and potential methodology.

Returning to the original proposition of the problem identified in the opening chapter; health is defined by values and positions; 'health in all' policies focuses on creating and improving the conditions for health while health policy is dominated by health care and treatment of disease. Health policy decisions impact everyone in society and policy making more broadly have been articulated as a web of decisions that take place over time, taking account of conflicts and tensions between politics, culture and interests. The cost of medical procedures, pharmaceuticals and treating diseases escalate at the same time that there is a continuing community expectation for the public provision of services. Health policy is dominated by the influences of medical procedures, pharmaceuticals and insurance. A fundamental policy shift to a 'health in all' policies approach would acknowledge the multiple influences of social, economic and environmental factors on health and challenge the dominant and, arguably, flawed discourse of individual choice and market responsibility. These factors influence health and social policy decisions by governments, and will not change fundamentally without a change in discourse that

acknowledges a public policy role in the promotion of health itself, which is determined through the circumstances and potential for choices that people have in their lives.

The dynamics of health policy change and, in particular, the implication of a change to a focus on 'good health' and a 'health in all' policies approach represents, therefore, a fundamental ideational change. The definition of health policy referred to in the opening chapter was described as being concerned with the distributional decisions that allocate "tangible benefits and services across various interests in society" (Palmer & Short, 2010) p48. Health policy is a product of complex and dynamic relations that result from the social and equity determinants of health that impact at the household level, in schools and workplace settings, and at the broader macro levels of society with access to transport, jobs and secure housing. Governments need to "take into account the impact of social, environmental and behavioural health determinants, including economic constraints, demographic changes and unhealthy lifestyles and living conditions" (Kickbusch & Behrendt, 2013, p1). Health 2020 (WHO, 2012) stated that integrated policies were needed that would work across governments and society to avoid the consequential poor health outcomes that would occur otherwise.

The case study and analysis of this thesis have demonstrated the dominant discourse is that of a rational health policy model that assumes there is a clear body of evidence from the past that informs the future decisions for allocative policy making. Policy making in practice has, however, been shown to be more discursively informed with evidence of emergent approaches that are willing to accept complexity, as described for example, by Beland (2010). The former head of the Victorian State Government Health Department referred to a "tyranny of complexity" (Philip, 2015) and the need for new models and ways of thinking that are "demanded, but have not yet clearly emerged". A 'health in all' policies approach would require the redistribution of power and resources (Marmot, 2015), take account of the interdependencies of all government and non-government agencies and, at the very least, extend the biomedical model to a social one. In order to make such an ideational health policy change there has to be an acknowledgement of the explicit shared responsibility and accountability mechanism across government agencies and at all levels of government. This would provide the opportunity to examine and challenge the contemporary features and structures of institutional governance, and the relationships inside and outside of government, and establish the capability for actors and organisations to work together and with citizens.

The first case study chapter examined the process of getting primary health onto the agenda for the Tasmanian Health Plan, and it seemed in part to be through the development of a narrative of urgency. Fundamental change in health policy requires the political acknowledgement of 'wicked' problems (Australian Public Service Commission, 2007) that do not have an agreed definition or solution and take time and commitment beyond the usual election cycle for governments, but they also need to be seen as urgent. This acknowledgement would be reflected in institutional arrangements and processes that

could then be more flexible and reflective in, for example, the use of emergent strategy and complex evaluation.

Discourse can be applied as a general explanatory term for the ‘communicative action’ of Habermas (Collier & Esteban, 1999) or Dryzek’s ‘deliberative democracy’ (Dryzek, 1994). Alternatively, it could be seen as a call for the ‘authentic conversation’ of Ezioni’s (1994) communitarian perspective for the rules of engagement that Adams describes as the ‘people power’ of authentic public engagement that would take consideration of the need to “re-think the temporal and spatial powers of public administration. The ahistorical, atheoretical and episodic nature of contemporary public administration [that] has resulted in a disjointed approach to public knowledge where the rhetoric and the reality are a long way apart” (Adams, 2004, p40). Reddel (2002) adapted the need for new governance arrangements as follows:

| | New Public Management | New Governance |
|----------------|---|---|
| Problem focus | Technical – focus on outcomes and outputs | Political – focus on ownership with vision driving strategic change |
| Culture | Public interest is ‘owned’ by executive and bureaucracy, based on consumer choice | Build ad hoc coalitions for change; complexity of policy issues; and open process with adequate closure |
| Implementation | Confrontation, agreement and compromise based on the ‘contract’ | Coalition building but confrontation when appropriate |
| Skills | Technical expertise based on performance assessment and the monitoring of contracts | Stakeholder analysis, diplomacy and communication strategies based on dialogue, deliberation and association |
| Infrastructure | Bureaucratic and expert structures with representation of directly affected interests | ‘Place’ based on more centralised arrangements involving elected community representation and ad hoc coalitions |

Figure 33 New Governance (Reddel, 2002, p59)

However, the process of governance and decision making in governments needs to also take account of the social and economic determinants that are impacting on the disparities in health outcomes. As inequalities continue to grow there has been an increasing interest in complexity and systems-based thinking to add insight into how to improve public policy for better health outcomes and the reduction in difference for some populations (Marston, 2010; Exworthy & Hunter, 2011; Bevan & Hood, 2006; Smith, 2013 Graham, 2009). Public services are the safety net for the most disadvantaged and vulnerable, and provide the potential for expertise and honest brokerage to facilitate the best outcomes between governments, citizens and private and not for profit organisations. For example, government policy to address unemployment could establish networks between the working and the unemployed so as to better connect the unemployed, creating opportunity for employment and for a multiplier effect to enhance the intended impact. In contrast to this, policies that require the unemployed to report to government centres provide connections between the unemployed with each other and are less likely to create employment (Hall & Thelan, 2009). If capacity and capability is developed and valued over time, this could open up the opportunity for a new revival of public service (Lindquist et al, 2011).

The barriers to policy and practice change documented in the health policy and public policy literature have been examined in chapters 1 and 2, and in the case material and analysis that follow in chapters 4,5 and 6. There is an evident complexity in the primary and community health field, not only because of the broad variety and range of actors and institutions, but also because of the ways in which problems and issues are differently identified, and then articulated and weighted as implementation and engagement occur. Primary and community health compete for funding and resources within an uneven playing field and a 'health in all policies' approach aligns with a comprehensive primary health approach which was the intentional direction set by the Tasmanian Government with the THP. However, the construction and processes of public administration are changing more generally for governments. At the same time that there is a general distrust in government, there is a call for more public service. At the same time that there is a loss of skills within the policy makers of government, there is an awareness of epistemological positions held by public servants, relating to deeply held values and positions that are pertinent to ideational long term change. The case study and analysis in this thesis found that the skilled and persistent internal advocacy for change by sentient agents within the institutional arrangements was a key feature for gaining traction toward a way forward. This has provided some insight to the complexity within the discourse itself, stretching from governments at all levels, through to community sector organisations, academic institutions and individual citizens. The thesis has extended the understanding of institutional theory in practice particularly with regard to agency and ideas, and highlighted the importance of governance and the role of notions such as "stewardship" for long term change capability within government agencies.

The first section of this final chapter builds on the insights of these findings to suggest that the next steps for fundamental health policy change are to extend the implications for institutional form and reform in government agencies, and consider the implications for public policy leadership and collaborative organisation.

Governance within health settings has been variously defined, but a useful definition in context is, "the attempts of governments or other actors to steer communities, whole countries or even groups of countries in the pursuit of health as integral to wellbeing through both whole-of-government and whole-of-society approaches" (WHO, 2011b) Creating and maintaining partnerships for health involves new ways of thinking about organisational form, structure and functioning. Relationships are key and will require open, transparent and respectful dealings between actors and institutions. Networked structures may be more appropriate than conventional bureaucratic forms. Methods of decision-making, resource allocation and accountability need to be highly visible and open to scrutiny and influence by everyone. This concluding chapter suggests some of the opportunities for health policy change that can be realised.

8.1 Health policy change

Contemporary thinking from the World Health Organisation (WHO) provides a vision for good health as a positive focus for health policy, as distinct from activity that has been dominated by the treatment of illness and disease. There is a considerable level of interest and debate, but a lack of leadership in Australia, where there has been a reduction in government funding for primary health and health promotion, and a vacuum in the level of maturity in terms of critical policy thinking. There are greater influences on government decision-making than ever before, including the private sector and other new institutional expertise such as think tanks, and professional advocacy and lobby organisations. This is occurring at the same time that governments have fewer fiscal resources and a diminishing public trust in what they do. The profound questions of social justice, in terms of equality and participation, are as critical as the practical considerations of service provision, if a positive health policy focus is to advance. The 'good society' is one where health and health equity are highly valued and improve over time. "[...] inequities in power, money and resources give rise to inequalities in the conditions of daily life which in turn lead to inequalities in health" (Marmot, 2015, p258). There is a strong popular concern about the burden of chronic conditions, but the policy discussion is still predominantly within a rational and deductive biomedical model approach, with the only focus on prevention tending toward a behaviour-modification approach, or a focus on 'lifestyle drift' (Raphael, 2008; Popay et al., 2010; Baum, 2011; Carey et al., 2016).

The Regional Committee for Europe²⁸ adopted the "Health 2020 Policy Framework and Strategy", which makes the following comment in its opening summary (WHO Regional Committee for Europe, 2012, p1):

Good health benefits all sectors and the whole of society, making it a valuable resource. Health and wellbeing are essential for economic and social development and of vital concern to the lives of every person, family and community. Poor health wastes potential, causes despair and drains resources across all sectors. Enabling people to exercise control over their health and its determinants builds communities and improves their health. Without people's active involvement, many opportunities to promote and protect health are lost. This entails putting in place collaborative models of working, based on shared priorities with other sectors (e.g. educational outcomes, social inclusion and cohesion, gender equality, poverty reduction, and community resilience and well-being). Action on those determinants of health that represent outcomes for these sectors leads to wider benefits for society and corresponding economic benefits.

In order to apply this in policy practice, and particularly in the consideration of health policy change, there needs to be an understanding of a political science analysis of policy. Health policy is less an intervention, but rather it drives intervention and development (de Leeuw,

²⁸ WHO Regional Committee for Europe, at the sixty second session in Malta on 10-13 September 2012.

et al., 2014). Therefore, understanding policy processes is ‘pivotal’, and needs to recognise the ‘wicked, multi-level and incremental’ nature of the elements involved.

There is a complexity of interrelationships between actors and institutions within countries and at the sub-national jurisdictional level, as well as the impacts of globalisation and interactions between countries. The Health 2020 report (WHO Regional Committee for Europe, 2012) like others such as the Commission on the Social Determinants (WHO, 2008) and Wilkinson and Pickett’s work (2009) refers to the knowledge about the links between health and economic growth. The links are demonstrated between health and social coherence in that better health is relative to perceived wealth and reliance on security benefits. The case is made for policies that aim to ensure decision-making power for citizens and increase their autonomy and independence, protect their rights and prevent discrimination, and reduce inequities. Shared decision-making and control over one’s health and its determinants are argued as vital, as well as the provision of services that are based on respectful communications between caregivers and recipients. The requisite structures and resources need, the 2020 report argues, to be available to citizens to enable them to fulfil their potential and participate fully in society, with access to knowledge and to health promotion and disease-prevention activities.

‘Adaptive’ policy is proposed by Carey (Carey et al., 2015) as a conceptual approach to reducing avoidable inequities between populations, groups or individuals. The term refers to a dynamic policy practice of learning through action, reflection and review as the evidence emerges. It could address complex issues where ‘static policy’ is unlikely to help meet the desired ends. The current policy approaches provide no “facility to deal with the unintended consequences of their implementation, including those which exacerbate the target problem, or create new and unexpected problems” (Carey et al., 2015, p763). It is challenging to apply this interdependent systems thinking approach to the practicalities of fundamental health policy change, because while we describe and perceive the need to see the whole, we do not actually have the ability to see it, hold it, describe it or manage it. In exploring the practical development of a chronic disease strategy, Chapter 6 referred to Wagner’s Chronic Disease Model (Wagner, 1998) that is one of the best known frameworks for using a systems-based approach to informing policy for preventing and managing chronic disease. This model has been adapted and adopted by a number of countries including Australia. Tasmania adopted the Wagner model to inform the chronic diseases strategy under the PHSP (DHHS, 2005b; DHHS, 2008b). The framework is popular, and is illustrative of the consistency of a broad approach to the consideration of health, particularly for the support of people living with chronic conditions. However, the evidence about the implementation of the whole framework is harder to find. Instead, the strategies adopted at the national and sub-national levels become drawn into particular areas of emphasis, such as diabetes management or hospital avoidance programs, which adapted aspects of the framework such as self-management support, a patient focus, or the design of the service delivery system.

The whole system is, inevitably, different to the sum of its parts, but there is both interest and opportunity, as well as an imperative of current unsustainability, to establish new policy practice that acknowledges and accepts the tensions that go with this complexity. Complexity theory, according to Klijn's review (Klijn, 2008, p291) suggests that there are too many people involved and too many simultaneous processes to consider and seek to influence positive change. However, continuing to focus on the linearity of the past will also continue to "[...] take us further away from understanding how to create change in real world settings. Moving the agenda [for fundamental health policy change] forward requires more sophisticated policy approaches that can deal with complex, non-linear relationships that drive inequalities ... despite the challenges of realpolitik." (Carey et al., 2015, p736).

The current reality is that primary health policy is poorly defined in terms of what constitutes good health and in the consideration of population health approaches and focus. Publically provided primary health and community services are fragmented, highly variable, and incomplete. The importance of the changes that are needed in health systems, and the challenges to changing them are especially relevant because of the increasing population-level differences in health outcomes. Health policy as it is currently applied incorporates difference in exposure and vulnerability for particular individuals and populations, but does not apply itself substantively to ensure equitable access to care. The extension of a social model, by the association of health as a basis for everyday life, provides policy opportunity for functional support to the environmental, behavioural and social factors that impact and influence our health. However, this is required without the individual focus of health policy that inevitably leads to the emphasis on the individual rather than the development of environments to promote health.

Today's health problems are difficult to solve because of their complexity, their multifaceted and multi-level nature, and rapidly changing dynamics within them. Economic, social, political and cultural processes operate throughout life, determining social position and cohesion. Problems such as mental health, social isolation, family violence, problematic alcohol and drug use, increasing health inequities, financial pressures on health and welfare system, and intergenerational poverty all increase the need for policy innovation. There is a need to recognise that many of the contemporary health policy challenges are 'wicked' issues that need a systems thinking approach to make population level progress.

The term 'wicked' problems (Australian Public Service Commission, 2007) has been applied to such issues that are difficult to solve because of their incomplete, unstable, contradictory and changing features. Many 21st century health challenges such as obesity are acknowledged to be 'wicked' problems. Attribution is complex, and linear relationships between cause and effect are hard to define. 'Wicked' problems need to be considered and analysed as complex problems using systems-based approaches to understanding them. Health policy is, therefore, potentially broad enough to include not only the primary and population approaches of 'health in all' policies, but also could include any policy that considers citizen and civil society approaches. A distinction is made between the "policy primeval soup" described by Kingdon (2003) and the metaphor of juggling introduced by de

Leeuw et al (2014) that aims to makes sense of the ‘logic, diligence and structure of managing a chaotic process’. Smith (2013) identifies the significant challenge for policy actors to maintain ‘whole systems’ complex adaptive thinking, that so many have argued is required, but suggests that ideas continue to resonate over time with the dynamic relationship between researchers and practitioners. This connection between complex adaptive systems-based thinking and healthy public policy has been made by Clavier and de Leeuw (2013) and, in their observations of UK health care, by Greenhalgh (Greenhalgh et al., 2012; Best et al., 2012).

Given these challenges to progressing a fundamental change to health policy, Health 2020 suggests (WHO Regional Committee for Europe, 2012, p31) that “policies should be implemented as large-scale experiments in which monitoring and evaluation efforts provide an essential mechanism for the policy community to learn from the experiences acquired in practice and to adapt accordingly. Obesity is an excellent example of a 21st century ‘wicked’ health challenge. The risk patterns and behaviour associated with the spread of the obesity epidemic are complex and multidimensional. Risks are local (such as the absence of playgrounds or lack of bicycle lanes), national (such as the lack of food labelling requirements) and global (trade and agriculture policies). Only a systems-wide approach and multiple interventions at different levels of governance, which recognize the complexity and ‘wicked’ nature of tackling obesity, will stand any chance of success.”

The theoretical reflection on network governance performance and effectiveness considers whether the work of Provan and Kenis (Clavier & de Leeuw, 2013, p167) is helpful in explaining the continual trade-off between collaborative action, internal organisational goals and objectives, and the efficiency of the achievement of objectives. This is summarised in the following table:

| <i>Governance forms</i> | Trust | Number of participants | Goal consensus | Need for network level competencies |
|--|--|-------------------------------|-----------------------|--|
| <i>Shared governance</i> | High density | Few | High | Low |
| <i>Lead organisation</i> | Low density – highly centralised | Moderate number | Moderately low | Moderate |
| <i>Network administrative organisation (NAO)</i> | Moderate density – NAO is monitored by members | Moderate to many | Moderately high | High |

Figure 34 Key predictors of effectiveness of network governance forms (Provan & Kenis, 2008)

A review of three separate health and community care services in London that received modernisation funds for whole system change (Greenhalgh et al., 2012), found that there was some evidence of change, but that it was dependent on a significant investment in the development of the skills for partnership and collaboration, which was determined, in part,

through asking the participant staff and patients “how and why did change unfold?” The factors that would seem to be in common through network approaches that have been implemented are that they have government as a central ‘facilitator’ of change, with a variety of different methods and investments in collaboration, partnership and networks between agencies, communities and community sector organisations (Greenhalgh et al., 2004, Hyde, 2008). The literature analysis of institutions, actors and the relevance of each in the emergence and development of policy demonstrates the importance of discourse. This was key to the decision to use DI as a theoretical lens for this study because it builds on institutionalist theory to take account of the ways that ideas get traction. However, the seminal writers that combine the ideational perspective to institutional analysis such as Mark Bevir, Colin Hay and Vivien Schmidt do not propose a single view of the process by which ideas are conveyed, adopted and get traction in policy change.

8.2 Implications for public sector governance

Government ministers and ministries have a vital role to play in shaping the functioning of the public sector and enabling its contribution to improve society and the determinants of health. Unfortunately, their capacity to do so often falls short of what is required, and the organisation of public sector systems has not kept pace with the changes that societies are undergoing. In particular, health services in the public sector and health policy capacity are relatively weak. Too little attention has been paid to developing community based and population health approaches, and other ways to meet the burden of chronic diseases through more structural and systemic support. Further, the usual hierarchical organisation of health care delivery systems makes them less capable of responding rapidly to technological innovation and to the demands and desire for participation of patients and communities. Because of these factors, health systems are significantly less productive in producing health than they could be. These same structural impediments to change are evident in other public institutions, but are probably more complex in health because of the range of professionals, settings and levels of governance. In order to get things done, the number and range of interactions, and the multiplications of links between agencies, people, services and service types is increasing. At the same time the conventional public administrative accountability structures are failing because policy implementation is neither linear nor predictable. Expectations of governments has changed and there is recognition of the need for more direct participation across sectors and, with citizens, to approach complex societal issues (Kickbush and Gleicher, 2012). The Northern Ireland Government developed a taxonomy for contemporary policy making that is represented in Figure 35, and demonstrates some of the range of sources of evidence to assess whether policy progress is being made.

| | |
|------------------|---|
| Forward thinking | Long term view based on statistical trends and informed predictions of the probable impacts of policy |
| Innovative | Questioning established methods and encouraging new ideas |

| | |
|----------------------|---|
| Informed by evidence | Using the best available evidence from a range of sources |
| Inclusive | Taking account of the impact of the policy on the needs of everyone directly or indirectly affected |
| Joined-up | Horizontal or vertical integration |
| Adaptive | Learning from experience of what works and what doesn't |
| Evaluative | Including systematic evaluation |
| Accountable | Being democratically legitimised, transparent and responsive to the demands of citizens |

Figure 35 Features of contemporary policy making (Adapted from the Government of Northern Ireland, 1999).

Engagement is complex because it includes the capability for people to take on their own health, through to being involved in health care services and to the evaluation and development of policy. It could be argued, for example that parents who manage to prevent their families from eating junk food not only care for their children's health but also contribute to the co-production of population health outcomes (Alford, 2009). Inequalities, however, are continuing to grow and there has been an increasing interest in whether system science and systems-based thinking may potentially provide insight into what may work to improve population health outcomes and reduce disparities. Upstream action, as identified in Figure 3 in chapter one (Keleher, 2004), is emphasised above the programs or policy interventions that target individuals, because the determinants of health "affect the organisation of material and social resources amongst the members of societies which is best addressed through government action" (Raphael, 2006). Carey and colleagues (Carey et al., 2014) analysed 15 studies of 'health in all' policies or 'joined-up' government approaches. These were case-based studies of 'instrumental process-based interventions' that were intentional in creating healthy public policy, rather than being inherently intended to improve health. This research found implementation to be in its relative infancy and proposes the need for a supportive and informal architecture' that includes the explicit combination of structural and cultural support.

The Marmot review of health inequalities in England found that, despite various attempts to collaborate across institutions and agencies, there are limitations in the extent that this occurs in practice (Marmot, 2010), or is sustained when it does occur, for example, through a requirement of a particular program. Marmot's recommendation for governance in order to reduce avoidable inequities was to provide mainstream, rather than short term project-based, funding within a 'light' structure. This would assist locally-based service providers [local government and community and private sector organisations] to "shape effective interventions, understand impacts of other policies on health distributions and avoid drift into small-scale projects focused on individual behaviours and lifestyle." (Marmot, 2010, p29).

Adaptive systems thinking is popular in the contemporary practice discourse, but with short term implementation timeframes, changes that are made can be 'washed out' so that they have little longer term impact, and the system and its respective structural and institutional arrangements reverts to their status quo. A dynamic adaptive system approach cannot be supported by a static policy, rather it needs to be willing to adapt and change, and structurally supported to be able to continue to do so. Australian public policy continues to be dominated by the emphasis on heuristic simplicity, managerialism and the influence of private sector models (Bridgman & Davis, 2000). The Australian and New Zealand School of Government (ANZSOG) has been actively advocating for innovations in government practice with 'joined-up' government and whole-of-government approaches as well as greater levels of community engagement (O'Flynn & Wanna, 2008).

Complexity as a theory in social science can, according to Fuerth (2009), provide a more realistic description of the progress and flow of events. It brings to the study of change and policy, the sense that everything is indeed related to everything else. It acknowledges that this is incredibly 'inconvenient' for the established health professional disciplines, and for the institutions that rely on the insularity of bureaucracy and normative rules. Complexity reveals the lack of any unique or permanent solutions to major issues, and instead invites us to view policy and the consequences of policies as an 'unceasing interaction' with discontinuous forms of change and unintended consequences. At the societal level we, according to Fuerth, 'express ourselves through governance'. However, this is for the most part 'myopic and fragmented' (Fuerth, 2009).

Zigmund Bauman in a series of books considering aspects of modernity (Bauman, 2000, p50-51) discusses critical theory and public power which has, he argues, lost its potency and the capacity to enable. "The war of emancipation is not over. But to progress further, it must now resuscitate what for most of its history it did its best to destroy and push out of the way. Any true liberation calls today for more, not less of the 'public sphere' and 'public power'. It is now the public sphere that badly needs defence against the invading private sector – though paradoxically, in order to enhance, not to cut down, individual liberty."

The following figure provides a flow of what could be termed and applied as 'adaptive policy making'.

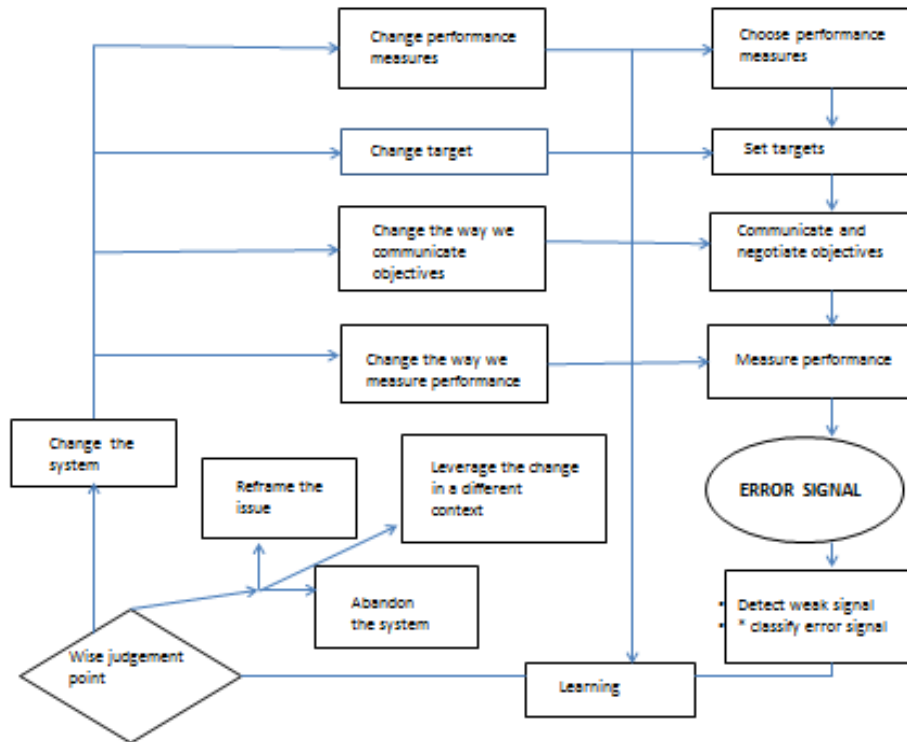


Figure 36 Adaptive policymaking (Stewart & Abbass, 2014)

The implications for the contemporary bureaucratic form of policy management are interesting for concluding this thesis. By reconceptualising the way that the public sector works with communities through increasing the flow of information and incorporating information loops, it could be possible for individual public agencies to operate far more flexibly than in the past, without sacrificing traditional accountabilities. Bureaucratic structure and process remains, but its informational drawbacks are mitigated by a more holistic and dynamic understanding of policy action. The ideas are elaborated further by Carey and Harris (2015) who acknowledge the value of key actors who form part of the social memory for institutions within an underlying structure, using ‘functional’ goals and targets rather than performance measures that are embedded within a broader adaptive process of learning. The purpose of ‘functional’ targets is to manage the current constraints of novel approaches to policy making by setting interim performance measures that can be reviewed and amended as implementation progresses. The key point in Figure 35 is that of learning.

This is not to suggest that government agencies should draw up comprehensive systemic maps of what they are trying to achieve because this will lead to an inevitably complex and unworkable understanding that establishes everything is connected to everything else. Rather, the starting point to proceed in this way would focus on the points at which agencies are able to facilitate adaptation, by interpreting existing modes of action (particularly the ways in which they understand, measure and act upon performance) in relation to the options suggested in Figure 35. There is a risk that governments will use the notion of evidence-based policy decision-making as a mechanism to legitimise the policy

decisions that have already been made. In this way, evidence is sometimes used to support particular priorities. Sanderson (2000) examines this in relation to the need for acknowledgement of complexity, and links evidence-based policymaking, evaluation and new institutionalism together with trying to meet the challenges of 'cross-cutting' policy problems. Accountability itself is also complicated by the extension of its meaning and reach to include 'public interest' measures of the extent to which there is social improvement. This itself is determined subjectively by prevailing discourses and moral philosophy. Considine (2002), for example, called for more emphasis on the horizontal accountabilities, and a 'culture of responsibility' rather than the over-emphasis of performance accountability in the vertical sense, which is a further factor in stifling adaptation. The dynamic combination of conceptual and practical challenges for contemporary public administration is significant, and governments face continuing tensions between 'accountability, aspirations and reality' (Lewis, 2014).

8.3 Leadership in public service policymaking

There are characteristics of a new public sector leadership for policy within the changing environment of public administration that no longer has a conventional authority, or clear causal leadership pathway through the elected members of government. The scholarly literature is comprised mainly of the commentary focused on the observation and causes of declining policy capacity (Gleeson et al., 2010; Aucoin & Bakvis, 2005; Halligan, 1995).

Establishing a significant policy change takes time and the skilled practice of knowledgeable practitioners. This research has provided understanding of the ideational change and the agency and persistent leadership required to make progress in changing health policy. Focusing on the 'sentient agents' of change is important because it emphasises the fact that "who is speaking to whom about what where and why or the interactive processes of discourse makes a difference" (Schmidt, 2011b,p116). The opportunity and the challenge presented by the significant service reorientation in Tasmania's health services through its Health Plan was, and still is, a response to the accelerating burden of chronic diseases and the consequences of this for those affected: the broader population and the workforce.

These same challenges are being faced across the developed world, particularly in Canada, the USA, and Europe, including the UK. Populations are ageing, and the number of new graduates is reducing at a greater rate than the number of the workforce who want to retire, leaving governments under increasing pressure to provide more for less. There is a conservatism in risk-averse policy at the same time as a requirement for public servants to be flexible and agile in responding to change. Dickinson (Dickinson & Sullivan, 2015, p23) posed the question "are public servants on the brink of transformative change?" and proposed that the emergent roles are that of commissioning, curating, story-telling and "foresighter" which is long term strategic thinking and analysis. Notably, the authors

highlight the need for skills in co-production which is the engagement with citizens, patients and clients of services to develop reciprocal arrangements.

The imperative for working together across and within departments, and with citizens and service users, has been long understood, and was strongly articulated in the THP analysed in this research. Implementation is reliant on cooperation between and within different organisations and is highly dependent on networks, partnerships, collaborations and relationships. Whilst fiscal pressure with significant variation in expenditure and cost will tend toward more competitive and cost shifting behaviours between business areas, this research has demonstrated that it is likely to be attention to the interdepartmental relationship components of system reform that will realise results.

The management emphasis on results tends towards the provision of fairly immediate feedback and affirmation, which can be powerful rewards in themselves. But in a public service where there is little, if any, incentive to be found in remuneration or other material rewards, leadership on these terms has little to offer. Not only does it take longer to make real changes, but it also presents some fundamental threats to stability. Leadership implies a requirement to deal with chaos, uncertainty and conflict. This contrasts with the orthodox view of the public servant as implementing the priorities and strategies set by government (Bridgman & Davis, 2000). However, without the leadership of public service executives, public servants would, arguably, be unable to achieve what governments require of them.

With the increasing complexity of problems that are faced by government, including new instruments such as consultation that have been set up for dealing with them, there is arguably a greater than ever need to apply leadership. Primary health policy, for example, is driving an increasing requirement for local community governance models that foster the opportunity for building capacity and participation in determining local health needs. However, at the same time this places considerable demands on public servants to support and deliver services in an environment of tension, with levels of understanding that vary in each location, and among staff groups, patient or client groups and geographical communities.

One key capability of leadership is helping or enabling others to make meaning clear. When people are able to frame an issue differently, sometimes the very act of naming or describing the problems can open the possibilities for acting in ways that may otherwise have been outside of their view. The possibilities for change come through leadership and a structure that combines design and direction, with nurturing and modelling behaviour. The new skills for joined-up governance include 'problem-solving skills, coordination skills (getting people to the table), brokering skills (seeing what needs to happen), flexibility, deep knowledge of the system and, for front line workers both knowledge of how to work with their community...a willingness to undertake the emotional labour associated with relational working" (Carey and Crammond, 2015).

Public sector executives are required to harness the knowledge and expertise of diverse people and groups, to tease out underlying assumptions and make them explicit, and to build common ground and the momentum for change. These are the characteristics of the transformational leadership identified in the seminal work by Burns (1978) which draws on the deeper processes of influence that the leader needs to inspire in followers, by developing relationships that have the potential to “convert followers into leaders and leaders into moral agents.” (Burns, 1978, p4) These skills are described as creative and akin to the servant-leader (Boddy & Buchanan, 1992), and Kanter (1992) coins the term of ‘change architect’ to symbolise some of the innovation required. She identifies the need for “back-staging” as well as the already identified skills of leadership. This architecture includes three particular strategies of manipulating structures, relationships and language in order to create effective change.

It is in the area of relationship that the greatest opportunity for difference and conflict arises, and also, therefore, the opportunity for applying leadership skill. The managerial approach tends to avoid conflict, whereas the leadership approach seeks to harness its creativity. As early as the 1920s, Mary Parker Follett (in Burns, 1978) was advocating for a universal goal of integration, which she described as a “harmonious marriage” of differences. But this was not the harmony as expressed through the social scientific leaning of the leadership writing of the 1990s, but rather the process of growth, in which individuals do not sacrifice interest, suppress desires or compromise their values. Conflict, according to Follett, is to be seen as a necessary friction, literally the transmission of power by which we generate movement.

Peter Senge (1992) explored the idea of developing a learning-centred approach, which offers a high leverage for change. One feature of the framework is a series of reflective questions, based on the concept of the ‘ladder of inference’, starting with “I take actions based on my beliefs” and ending with “I observe data and experience”. This is intended as illustrative of the thought processes which commonly lead people to make judgements. The practice of inquiry and reflection provides employees and employers the opportunities to explore the reasoning and attitudes that underpin their decision making and actions. Employees are not a homogenous group and one of the fundamental challenges in developing a leadership approach through an organisation is that the techniques used are often applied generally. This includes ideas such as team work, autonomous work groups and consultative committees which rarely have any real impact on attitudes and culture. There needs to be an integrated strategy adopted to facilitate a participative style of leadership within organisations, and where each individual can make their best contribution.

Dunoon (2002) makes the case for a learning-centred approach in the public service which is acknowledged as difficult in a context of competing pressures of tight resources and time constraints. However, if these tensions are explicitly acknowledged, then there may also be opportunities. Madison (Burns, 1978) is said to have described conflict as the “seedbed” of leadership: “Leadership acts as an inciting and triggering force in the conversion of conflicting demands, values and goals into significant behaviour.” It is the type of motivation that is encouraged or triggered that is critical, an appeal to a “civil society” (Hall 1996) that

aspires to a higher purpose and a moral code of values. What is often omitted in the management approach to leadership is that the individual employees' interests do not need to be sacrificed for the good of the organisation, but neither are their interests required to be met through some democratic process.

Citizens, according to Keating (2000), do not want less government so much as better government, and real solutions to their particular problems. The challenge that faces governments then is not so much a loss of power, through societal, economic and technological changes, but rather the need to adapt to the productive use of that power. The main differentiating factor for outstandingly successful companies is not visionary leadership or the use of any of the latest of management practices, but a commitment to a clear purpose and to core values. Success may be attributed to the maintaining of stable values over time whilst simultaneously creating and cultivating an ethic of change.

What is required then, is a new and more enduring leadership paradigm which is both substantive and transformational. An emergent framework that transcends the individualistic paradigm and that is moral without prescription, and ethical without preaching. Public service actors need to be afforded the professional status to facilitate the processes of policymaking over time, as a dynamic and continuing activity. The processes of policy are, according to public service policymakers interviewed by Adams (2005) "constituted not by order and rationality but by uncertainty, interpretation, contested meanings, power, volatility, compressed views of time and partial information ... practitioners are confronted with constant paradoxes". Leadership may fail to please everyone completely, but the hope is to move people beyond self-interest to a truly participative democracy. It is important that both leaders and followers, politicians, public servants and citizens alike, should aspire to this if sustainable services are to be achieved.

The leadership that is required is, at least in part, a renewal of the public management characteristics described by Weber (1968) and observed by Harold Finer (in Hess & Adams, 2007), as fundamentally focused on public interest and thus requiring the attitude of the public servant to have this as the sole goal of their work to the exclusion of any personal end. This was assumed to be the "natural and normative product of the prosper functioning of democratically elected government" (Hess & Adams, 2007, p8). They have the capacity to move people to share in the mutually rewarding visions of success and enable and empower them to convert vision into reality. There is a range of engagement for intersectoral work, in a way that parallels Arnstein's ladder of participation (Arnstein, 1969), acknowledging that each level in the Figure 37 that follows, carries its own complexity to manage with different implications for resource sharing and accountabilities. However, the opportunities for sharing the accountabilities for the issues that require joint action is an opportunity.

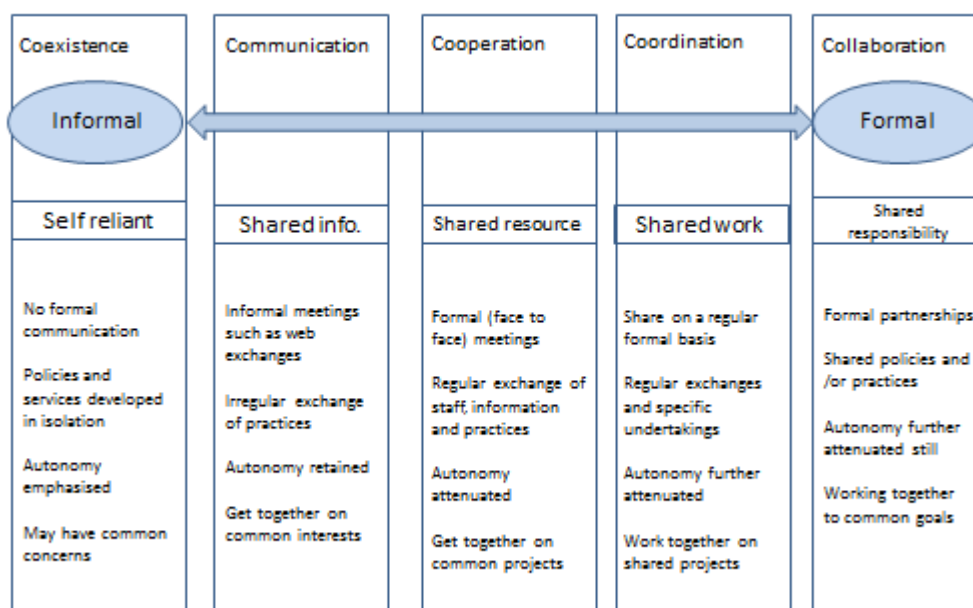


Figure 37 Continuum of intergovernmental integration. Adapted from (Boston & Gill, 2011)

DI has been theoretically useful in providing an understanding of the dynamics of policy change, and particularly within the complex environment of primary health policy with multiple actors, actor groups, institutions and public as well as market interests. The development of research in practice and to refine the research methodologies applying DI will require much closer partnerships and communities of practice between academic institutions and the institutions of government. Because DI focuses on the substantive ideas that are conveyed through discursive interactions, the “actions of sentient agents serve to alter (or maintain) institutions” (Schmidt, 2011b, p107). Speaking about change is key to fundamental health policy change as it is happening, rather than only understanding and analysing after changes have occurred. This dynamic is particularly relevant to fundamental health policy change which has not yet gained traction. Schmidt argued in an earlier article (Schmidt, 2006) that political scientists should explore the boundaries between methodological approaches. In order for innovation and understanding to deepen and indeed flourish, an investment is needed in communities of practice that cross the boundaries between academia and policy makers, and that guide policy analysis in order to continue to improve policy making in practice. The acceptance that policy making is a craft that needs continual development, is part of the proposition by Adams and Colebatch (2015, p103) who identified that “relationships and framing” are significant and interrelated skills to keep learning in order to manage and understand policy problems.

There is much more to be done to understand and apply ‘health in all’ policies thinking in practice, and to enable fundamental health policy change that will reduce health inequalities and the burden of chronic diseases by enabling more people and communities to have

better control over their own lives and experiences. The whole of society approaches (see Baum, 2002; WHO, 1991; WHO 2011; WHO, 2012; Kickbush and Gleicher, 2012) that are described as part of the complementarity to public policy emphasises coordination through normative values and trust building. There is a need for engagement that crosses the boundaries of inside and outside government, and which could enable the effective development of sustainably adaptive policymaking. By engaging the private sector, civil society, communities and individuals, a health in all policies or comprehensive primary health approach could strengthen the resilience of communities to withstand threats to their health and to build their strategies and infrastructure for wellbeing. This would be adaptive by continually learning through rigorous reflection on what works to fundamentally improve the health of populations and slow the trajectory of chronic conditions.

I look forward to the maturity within governments of recognising complexity in health policy and the importance of systems-based thinking approaches in applying a fundamental health policy change. Acknowledgement is needed for the critical realist interpretation of policymakers in practice linking with researchers. Further research could be invested in better understanding the role of the policymaker – as elected member, citizen or public servant. Investment is required, particularly in the amount of time needed for collaboration between different sectors for problem solving in complex environments where problems and solutions are both intersecting and connected. A harmonisation of global thinking and standards is required in order to apply them to local adaptation to tackle emerging issues in diverse contexts. Indeed, the renewal of a civil society discourse, so strongly described by Stone (2008, p6 and p292)

“We have to start by knowing that real people draw their life meaning from helping others, making a difference, and trying to do good.”

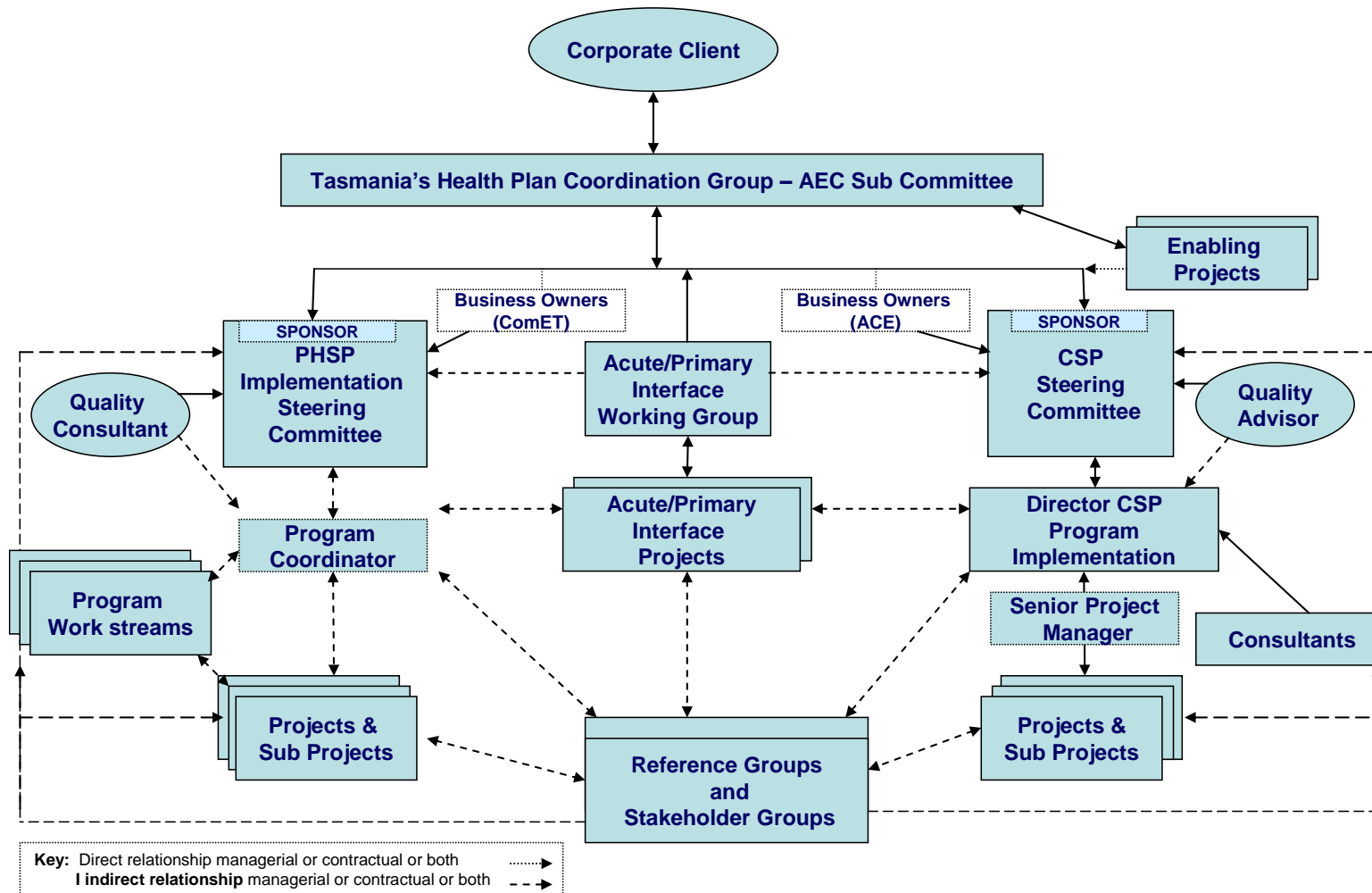
“We need leaders who reach citizens through their hearts and their hopes not their hatreds and fears. We need leaders who can show us how government can help us all by helping us to help each other. We need leaders who connect democracy with the cares that make us fully human. Let us welcome the Good Samaritan back into the public realm.”

Tasmania represents the perfect storm of an opportunity for deep engagement across multiple sectors. There has been genuine cross-party support from the Labor, Liberal and Green parties over a protracted period, which has led to a generally accepted position that the State's poor health outcomes are less a reflection of the health care policy and more about the structural social, economic and environmental conditions for daily living. There is a dynamic opportunity for the interface between this, and practice and research itself to establish good health for all. Levitas (2013) proposes the need to ‘reconstitute society’ fundamentally asserting that utopia is the expression of desire for a better future that is inherent in human culture. In piecing together images of good society that are embedded in political programmes and social and economic policies, we need to think how ‘future societies [may] become and be otherwise’ (Levitas, 2013, p66). At its heart, the opportunity

for fundamental health policy change can happen if we keep our feet on the ground and our heads firmly in the clouds of possibility and transformation.

APPENDIX 1: Structure of the THP Implementation (at December 2007)

Tasmania's Health Plan Implementation Governance



APPENDIX 2: Example of Project report Gantt Chart

| <i>Project Number</i> | <i>Project Name</i> | <i>June – Dec 07</i> | <i>Jan – Apr 08</i> | <i>May – Aug 08</i> | <i>Sept – Dec 08</i> | <i>Jan – April 09</i> | <i>May – Aug 09</i> | <i>Sept – Dec 09</i> | <i>Jan – April 10</i> | <i>May – Aug 10</i> | <i>Sept – Dec 10</i> | <i>Jan 2011 – ++</i> | <i>Dependencies</i> |
|-----------------------|---|----------------------|---------------------|---------------------|----------------------|-----------------------|---------------------|----------------------|-----------------------|---------------------|----------------------|----------------------|---|
| PHo6 | Preventing and managing chronic disease | | | | | | | | | | | | NSMo5, NSMo7 |
| PHo6a | Development of a statewide health promotion policy | | | | | | | | | | | | |
| PHo6b | Recruitment of Health Promotion Coordinators | | | | | | | | | | | | Contingent on development, endorsement of policy PHo6a |
| PHo6c | Identify population groups most at risk of chronic disease, with an initial focus on diabetes | | | | | | | | | | | | |
| PHo6d | Increase effort in cessation of tobacco smoking | | | | | | | | | | | | |
| PHo6e | Develop a policy framework for youth health services within Primary Health | | | | | | | | | | | | |
| PHo6f | Develop partnerships to encourage young people to engage in healthy lifestyles | | | | | | | | | | | | In line with existing policy PHo6e |
| PHo6g | Develop statewide Chronic Disease Self-Management Plan | | | | | | | | | | | | |
| PHo6h | Expansion of the approaches to chronic disease self-management | | | | | | | | | | | | In line with existing plan PHo6g |
| PHo6i | Greater capacity to prevent and manage diabetes and other chronic disease at primary health level | | | | | | | | | | | | In line with existing plan PHo6g |

| | | | | | | | | | |
|-------|--|--|--|--|--|--|--|--|--|
| PHo6j | Development of new models to expand rehabilitation services in the community | | | | | | | | |
| PHo6k | Increased access to mental health and alcohol and drug programs in rural areas | | | | | | | | |

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